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	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. 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), 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, Orencia (abatacept), Rinvoq/LQ, 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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months

Other Criteria	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.

ACTHAR GEL (S)

Products Affected

- Acthar
- Acthar Gel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	Infantile spasms: less than 2 years old
Prescriber Restrictions	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.

Coverage Duration	Infantile Spasms: 4 weeks. MS: 3 weeks. All other FDA-approved uses: 3 months.
Other Criteria	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^2 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.

ACTIMMUNE (S)

Products Affected

- Actimmune INJ 100MCG/0.5ML

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

ADALIMUMAB-AATY (S)

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe Kit

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. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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
Prescriber Restrictions	RA, AS, PJIA (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.

Coverage Duration	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 HS (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 evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) 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. 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.

ADALIMUMAB-ADBM (S)

Products Affected

- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

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. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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
Prescriber Restrictions	RA, AS, PJIA (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.

Coverage Duration	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 HS (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 evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) 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. 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.

ADBRY (S)

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ADEMPAS (S)

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, CTEPH (Reauth): Patient demonstrates positive clinical response to therapy.

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

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. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures.
Age Restrictions	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.
Prescriber Restrictions	TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

AFREZZA (S)

Products Affected

- Afrezza

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: 1) Diagnosis of type 1 diabetes mellitus and used in combination with a long-acting insulin (eg, Lantus) 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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 both of the following: A) prednisone or prednisolone, and B) Brand Emflaza or generic deflazacort. 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.
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a benefit from therapy.

AIMOVIG (S)

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	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

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

AKLIEF (S)

Products Affected

- Aklief

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

ALECENSA (S)

Products Affected

- Alecensa

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 NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)]. One of the following: 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) OR the patient has a concomitant diagnosis of necrotizing panniculitis. Trial and failure, or intolerance to Prolastin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

ALTRENO (S)

Products Affected

- Altreno

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

ALUNBRIG (S)

Products Affected

- Alunbrig

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 NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ALVAIZ (S)

Products Affected

- Alvaiz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	ITP (init): 12 mo. SAA (init): 16 wk. Hep C (init): 3 mo. All uses (reauth): 12 mo.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (Initial): 6 months. (Reauth): 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	PD (Initial): Not used with any 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Required Medical Information	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.).
Age Restrictions	N/A
Prescriber Restrictions	PD (Initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	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.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	CAPS, Recurrent Pericarditis (initial, reauth): 12 months. DIRA: 12 months.
Other Criteria	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

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

ARIKAYCE (S)

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	12 months
Other Criteria	N/A

AUBAGIO (S)

Products Affected

- Aubagio
- Teriflunomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

AUGTYRO (S)

Products Affected

- Augtyro

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 NSCLC. Disease is one of the following: a) locally advanced, or b) metastatic. Patient has ROS1 rearrangement positive tumor(s).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

AUSTEDO (S)

Products Affected

- Austedo
- Austedo Xr TB24 18MG, 30MG, 36MG, 42MG, 48MG
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated 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.
Age Restrictions	N/A
Prescriber Restrictions	Huntington's disease chorea (initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial: 3 months. Reauth: 12 months
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

AYVAKIT (S)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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). Platelet count is greater than 50 x 10^9/L. Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BAFIERTAM (S)

Products Affected

- Bafiertam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

BALVERSA (S)

Products Affected

- Balversa

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

BENLYSTA (S)

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	SLE, Lupus Nephritis (init): Benlysta IV (vial), SC (prefilled syringe): Patient is 5 years of age or older.
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist. Lupus Nephritis (init): Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	SLE, Lupus Nephritis (init, reauth): 6 months
Other Criteria	SLE, Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.

BERINERT (S)

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	N/A
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

BESREMI (S)

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Both of the following: 1) Trial and failure, contraindication or intolerance (TF/C/I) to hydroxyurea, AND 2) TF/C/I to one interferon therapy (e.g., Intron A, Pegasys, etc).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

BIMZELX (S)

Products Affected

- Bimzelx INJ 160MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 (TF/C/I) to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), or Stelara (ustekinumab). 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 SC, Enbrel, one formulary adalimumab product, Orencia (abatacept), Otezla, Skyrizi, Stelara, Rinvoq/LQ (upadacitinib), or Xeljanz/XR (tofacitinib), OR b) for continuation of prior therapy. Non-radiographic axial spondyloarthritis (nr-axSpA) (initial): Dx of active nr-axSpA. Patient has 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) TF/C/I to Cosentyx SC and Rinvoq, OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS) (initial): Dx of active AS. One of the following: a) TF/C/I to two of the following: Enbrel, one formulary adalimumab product, Cosentyx SC, Rinvoq, Xeljanz/XR, OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PsO (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.
Coverage Duration	PsO, PsA, nr-axSpA, AS (initial): 6 months. PsO, PsA, nr-axSpA, AS (reauth): 12 months.
Other Criteria	PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement

	from baseline, OR improvement in symptoms (eg, pruritus, 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, 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.

BOSULIF (S)

Products Affected

- Bosulif

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

BRAFTOVI (S)

Products Affected

- Braftovi CAPS 75MG

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

BRIVIACT (S)

Products Affected

- Briviact ORAL SOLN
- Briviact TABS

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

BRONCHITOL (S)

Products Affected

- Bronchitol

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

BROVANA (S)

Products Affected

- Brovana

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD: 12 months.
Other Criteria	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.

BYETTA BYDUREON (S)

Products Affected

- Bydureon Bcise
- Byetta

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.

BYLVAY (S)

Products Affected

- Bylvay
- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 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, 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 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, Welchol).
Age Restrictions	PFIC (initial): Patient is 3 months of age or older. ALGS (initial): Patient is 12 months of age or older.
Prescriber Restrictions	PFIC, ALGS (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	PFIC, ALGS (initial): 6 months. PFIC, ALGS (reauth): 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	3 months
Other Criteria	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. Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate). Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. 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	DTC: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CALQUENCE (S)

Products Affected

- Calquence

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

CAMZYOS (S)

Products Affected

- Camzyos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	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

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

CAPRELSA (S)

Products Affected

- Caprelsa

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

CARISOPRODOL (S)

Products Affected

- Carisoprodol TABS

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. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CAYSTON (S)

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs.
Age Restrictions	CF (Initial): 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	CF (Initial, reauth): 12 months
Other Criteria	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).

CERDELGA (S)

Products Affected

- Cerdelga

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

CHENODAL (S)

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist or provider who has specialized expertise in the management of gallstones
Coverage Duration	Initial, reauth: 12 months.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses: 4 months (initial), 12 months (reauth).
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement in liver function.

CIALIS (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use of nitrates.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CIBINQO (S)

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	(Initial): Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	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	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. 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, one formulary adalimumab product, Orencia, Rinvoq/LQ, or Xeljanz, OR b) 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 SC (secukinumab), Enbrel, one formulary adalimumab product, Orencia, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq/LQ, 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 SC, 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.
Age Restrictions	N/A
Prescriber Restrictions	CD (init): Prescribed by or in consultation with a gastroenterologist. RA, PJIA, 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.
Coverage Duration	RA, PJIA, PsA, AS, PsO, nr-axSpA (init): 6 mo, (reauth): 12 mo. CD (init): 16 wks. (reauth): 12 mo.

Other Criteria	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. 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 (CDAI) 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. 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. 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 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.

CINRYZE (S)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

COBENFY (S)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: a) aripiprazole, b) asenapine, c) olanzapine, d) paliperidone, e) quetiapine (IR or ER), f) risperidone, or g) ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

COMETRIQ (S)

Products Affected

- Cometriq

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

COPIKTRA (S)

Products Affected

- Copiktra

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

CORLANOR (S)

Products Affected

- Corlanor
- Ivabradine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	CHF, DCM (initial): Prescribed by or in consultation with a cardiologist
Coverage Duration	CHF, DCM (initial, reauth): 12 months
Other Criteria	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	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 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).
Age Restrictions	IS: less than 2 years old
Prescriber Restrictions	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.

Coverage Duration	IS: 4 weeks. MS: 3 weeks. Other FDA-Approved Indications: 3 months.
Other Criteria	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^2 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	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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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.
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.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	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 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. 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.

COTELLIC (S)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm. Used as monotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

CRESEMBA ORAL (S)

Products Affected

- Cresemba CAPS

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

CRINONE (S)

Products Affected

- Crinone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CUPRIMINE (S)

Products Affected

- Penicillamine CAPS

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: 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., adalimumab, Enbrel (etanercept)], Non-TNF biologic [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy

CUVPOSA (S)

Products Affected

- Glycopyrrolate ORAL SOLN

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

CUVRIOR (S)

Products Affected

- Cuvrior

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

DALIRESP (S)

Products Affected

- Daliresp
- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD (init, reauth): 12 months
Other Criteria	COPD (reauth): Patient demonstrates positive clinical response to therapy.

DARAPRIM (S)

Products Affected

- Daraprim
- Pyrimethamine TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasmosis: Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Toxoplasmosis: 12 months
Other Criteria	N/A

DAURISMO (S)

Products Affected

- Daurismo

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

DAYBUE (S)

Products Affected

- Daybue

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a geneticist or neurologist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

DAYVIGO (S)

Products Affected

- Dayvigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of insomnia. Trial and failure, contraindication, or intolerance to Belsomra (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 or age AND trial and failure, contraindication, or intolerance to one of the following: eszopiclone, temazepam, zaleplon, zolpidem, zolpidem ER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

DEFERASIROX (S)

Products Affected

- Deferasirox
- Exjade
- Jadenu Sprinkle

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
Other Criteria	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.

DEMSER (S)

Products Affected

- Demser
- Metyrosine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	Preop prep: 4 wks. Treatment of pheo (initial): 6 months, (reauth): 12 months.
Other Criteria	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

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

DIACOMIT (S)

Products Affected

- Diacomit

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

DIBENZYLINE (S)

Products Affected

- Dibenzyline
- Phenoxybenzamine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 one of the following: a) doxazosin, or b) prazosin.
Age Restrictions	N/A
Prescriber Restrictions	Preop prep: prescribed by or in consultation with an endocrinologist or endocrine surgeon.
Coverage Duration	4 weeks
Other Criteria	N/A

DOPTELET (S)

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 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.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	TPPP: 1 month. ITP (initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

DULERA (S)

Products Affected

- Dulera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 trifenatate).
Age Restrictions	Initial: Patient is 5 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Asthma (reauthorization): Patient demonstrates positive clinical response to therapy.

DUOPA (S)

Products Affected

- Duopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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]).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	Subject to Part B vs. Part D review. PD (Reauth): Patient demonstrates positive clinical response to therapy.

DUPIXENT (S)

Products Affected

- Dupixent INJ 200MG/1.14ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. 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 100–200mcg 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, Wixela Inhub [fluticasone propionate 100mcg/salmeterol50mcg], budesonide80mcg/formoterol4.5mcg, Breo Ellipta [fluticasone furoate 50mcg/vilanterol 25mcg]) 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, Wixela Inhub (fluticasone propionate 500mcg/salmeterol50mcg), budesonide160mcg/formoterol4.5mcg, Breo Ellipta (fluticasone200mcg/vilanterol25mcg)].
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.
Prescriber Restrictions	AD, PN (Init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. Asthma (init, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP

	(init, reauth): Prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (init): Prescribed by or in consultation with a gastroenterologist or allergist/immunologist. COPD (init, reauth): Prescribed by or in consultation with a pulmonologist.
Coverage Duration	CRSwNP, EoE (Init/Reauth): 12 mo. Asthma, AD, PN, COPD (Init): 6 mo, (reauth): 12 mo.
Other Criteria	Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Dx of CRSwNP. Unless contraindicated, the patient (pt) has had an inadequate response to 2 mo of tx with an intranasal corticosteroid (CS) (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic esophagitis (EoE) (init): Dx of EoE. Pt has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, GERD/heartburn symptoms, chest pain, abdominal pain). Pt has at least 15 intraepithelial eosinophils per high power field. Other causes of esophageal eosinophilia have been excluded. Pt weighs at least 15 kg. Trial and failure, contraindication, or intolerance (TF/C/I) to at least an 8-wk trial of 1 of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) CS (eg, budesonide, fluticasone). PN (init): Diagnosis of PN. TF/C/I to 1 medium or higher potency topical CS (TCS). Atopic dermatitis (AD) (init): Dx of mod to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing AD (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for TCS), contraindication (CI) (eg, safety concerns, not indicated for pt's age/weight), or intolerance to 1 of the following: a) Medium or higher potency TCS, b) Pimecrolimus, c) Tacrolimus ointment, or d) Eucrisa (crisaborole). Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of type 2 inflammation evidenced by baseline blood eosinophils greater than or equal to 300 cells/mcL. Pt is receiving 1 of the following at maximally tolerated doses: triple therapy [ie, an ICS (eg, budesonide), a LAMA (eg, tiotropium, umeclidinium), and a LABA (eg, salmeterol, arformoterol, formoterol)] OR if CI to ICS, a LAMA and a LABA. Pt has had at least 2 exacerbations where systemic CS [IM/IV/oral (eg, prednisone)] were required at least once OR COPD-related hospitalization w/in the past 12 mo. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction in BSA involvement or SCORAD index value from baseline. EA, CDA, PN, CRSwNP, COPD (reauth): Pt demonstrates positive clinical response to therapy. EA, CDA (reauth): Pt continues to be treated with an ICS (e.g., fluticasone, budesonide) w/ or w/o additional asthma controller med (e.g., LTRA [e.g., montelukast], LABA [e.g., salmeterol], LAMA [e.g., tiotropium]) unless there is a C/I to these meds. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement of 1 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). COPD (reauth): Pt continues on triple therapy (ie, an ICS, a LAMA, and a LABA) OR if CI to ICS, a LAMA and a LABA.

DUVYZAT (S)

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Duchenne muscular dystrophy (DMD). One of the following: A) Patient has a confirmed mutation of the dystrophin gene, or B) Muscle biopsy confirmed an absence of dystrophin protein. Patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to initiating Duvyzat. Requested drug will be used concomitantly with a corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree).
Age Restrictions	Initial: Patient is 6 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pediatric neurologist with expertise in treating DMD.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a benefit from therapy. Patient continues to receive concomitant corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree).

EBGLYSS (S)

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis. Patient weighs at least 40 kg. 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, contraindication, or intolerance (TF/C/I) to two of the following: Adbry (tralokizumab-ldrm), Dupixent (dupilumab), or Rinvoq (upadacitinib).
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	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.

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^2, 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, nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, 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

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

ELYXYB (S)

Products Affected

- Elyxyb

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EMFLAZA (S)

Products Affected

- Deflazacort

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: Patient is 2 years of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient has experienced a benefit from therapy (e.g., improvement or preservation of muscle strength).

EMGALITY (S)

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (120 mg/mL strength only) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. 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. 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. 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.
Age Restrictions	EM, CM, ECH (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. ECH (initial): 3 months. EM, CM, ECH (reauth): 12 months.
Other Criteria	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
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 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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	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 evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) 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.

ENDARI (S)

Products Affected

- Endari
- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Sickle cell disease (initial): Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Sickle cell disease (initial, reauth): 12 months
Other Criteria	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.

ENSPRYNG (S)

Products Affected

- Enspryng

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

ENTYVIO (S)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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: one formulary adalimumab product, 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: one formulary adalimumab product, Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara, OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD (init): Prescribed by or in consultation with a gastroenterologist
Coverage Duration	UC, CD (init): 14 weeks. UC, CD (reauth): 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)].
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

EPCLUSA PREFERRED (S)

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)].
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

EPIDIOLEX (S)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	LGS, DS, TSC: Patient is 1 year of age or older.
Prescriber Restrictions	LGS, DS, TSC: Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	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
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. 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. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
Other Criteria	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.

ERIVEDGE (S)

Products Affected

- Erivedge

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

ERLEADA (S)

Products Affected

- Erleada

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

ESBRIET (S)

Products Affected

- Esbriet
- Pirfenidone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	IPF (initial): Prescribed by or in consultation with a pulmonologist
Coverage Duration	initial, reauth: 12 months
Other Criteria	IPF (reauth): Patient demonstrates positive clinical response to therapy.

EUCRISA (S)

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity).

EVENITY (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	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.
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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Initial, Reauth: 14 days
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

FABHALTA (S)

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal nocturnal hemoglobinuria (PNH) (Initial): Diagnosis of PNH. Hemoglobin level of less than 10 g/dL. Immunoglobulin A nephropathy (IgAN) (Initial): Diagnosis of primary 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 20 mL/min/1.73 m2. 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).
Age Restrictions	N/A
Prescriber Restrictions	PNH (Initial): Prescribed by or in consultation with a hematologist/oncologist. IgAN (Initial): Prescribed by or in consultation with a nephrologist.
Coverage Duration	All Indications (Initial, Reauth): 12 months
Other Criteria	All Indications (Reauth): Patient demonstrates positive clinical response to therapy.

FASENRA (S)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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., Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], 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., Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	N/A
Prescriber Restrictions	Asthma (Initial/Reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist
Coverage Duration	Asthma (init): 6 months. Asthma (reauth): 12 months

Other Criteria	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.

FERRIPROX (S)

Products Affected

- Deferiprone
- Ferriprox Twice-a-day

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 x 10^9/L. Trial and failure, contraindication or intolerance to one chelation therapy (e.g., generic deferasirox).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy. ANC greater than 1.5 x 10^9/L.

FILSPARI (S)

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 m2. 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).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a nephrologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 that require healing. 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.
Age Restrictions	Initial: Patient is 6 months of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a specialist with expertise in wound care.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	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. Medication is not being used concurrently with other FDA approved therapies (e.g., Vyjuvek) on the same target wound for the treatment epidermolysis bullosa.

FINTEPLA (S)

Products Affected

- Fintepla

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

FIRAZYR (S)

Products Affected

- Firazyr
- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	Initial: Patient is 18 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

FIRDAPSE (S)

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS) (initial): Diagnosis of LEMS.
Age Restrictions	LEMS (initial): Patient is 6 years of age or older.
Prescriber Restrictions	LEMS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	LEMS (initial): 3 months. LEMS (reauth): 12 months.
Other Criteria	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

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

FLECTOR (S)

Products Affected

- Diclofenac Epolamine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

FLUTICASONE-VILANTEROL (S)

Products Affected

- Fluticasone Furoate/vilanterol Ellipta

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

FOTIVDA (S)

Products Affected

- Fotivda

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

FRUZAQLA (S)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI), and B) Anti-VEGF biological therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-afibercept]). One of the following: A) Patient has RAS mutant tumors, OR B) Both of the following: a) Patient has RAS wild-type tumors, AND b) Patient has been previously treated with both of the following: 1) An anti-EGFR biological therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), and 2) One of the following: i) Lonsurf [trifluridine/tipiracil] or ii) Stivarga [regorafenib].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

FULPHILA (S)

Products Affected

- Fulphila

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	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 AND Udenyca.

FUROSCIX (S)

Products Affected

- Furoscix

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

FYLNETRA (S)

Products Affected

- Fylnetra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	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 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 α-galactosidase A (α-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 other drugs used for Fabry disease.
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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	SBS (initial): Patient is 1 year of age or older.
Prescriber Restrictions	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	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

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 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.
Age Restrictions	Thyroid Cancer: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

GILENYA (S)

Products Affected

- Fingolimod Hydrochloride
- Gilenya CAPS 0.25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	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

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): 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

GLATIRAMER ACETATE (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

GLEEVEC (S)

Products Affected

- Imatinib Mesylate

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

GLUMETZA (S)

Products Affected

- Metformin Hydrochloride Er TB24
  1000MG, 500MG

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) 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial, Reauth: 3 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All Indications (Initial): Prescribed by or in consultation with a neurologist
Coverage Duration	All Indications (initial, reauth): 12 months
Other Criteria	All Indications (reauthorization): Patient demonstrates positive clinical response to therapy.

GRASTEK (S)

Products Affected

- Grastek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	AR (Initial): 5 to 65 years of age
Prescriber Restrictions	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	AR (initial, reauth): 12 months
Other Criteria	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	PGHD(initial):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)]. 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.
Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	All uses (initial):Trial and failure or intolerance to Genotropin. 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. AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. 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].

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	PGHD(initial):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)]. 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.
Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	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. AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. 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].

HAEGARDA (S)

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

HARVONI (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

HETLIOZ (S)

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 hypernychthemeral 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).
Age Restrictions	SMS (initial): 16 years of age or older
Prescriber Restrictions	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.
Coverage Duration	Non-24, SMS (initial): 6 mo. (reauth): 12 mo
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	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 - 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 Pen
- Humira Pen-cd/uc/hs Starter INJ 80MG/0.8ML
- Humira Pen-ps/uv Starter INJ 0

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. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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
Prescriber Restrictions	RA, AS, PJIA (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.

Coverage Duration	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 HS (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 evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) 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. 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

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

IBRANCE (S)

Products Affected

- Ibrance

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

ICLUSIG (S)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL). One of the following: a) Used in combination with chemotherapy up to 20 cycles OR b) Used as monotherapy in patients where one of the following applies: i) No other kinase inhibitors are indicated OR ii) Disease is T315I-positive Ph+ ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.

IDHIFA (S)

Products Affected

- Idhifa

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

ILUMYA (S)

Products Affected

- Ilumya

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 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.

IMBRUVICA (S)

Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 420MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	(cGVHD): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.

IMVEXXY (S)

Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

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

INBRIJA (S)

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (initial, reauth): 12 months
Other Criteria	PD (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with carbidopa/levodopa.

INCRELEX (S)

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	(Reauth): Patient demonstrates positive clinical response to therapy.

INGREZZA (S)

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	All Uses (initial): 3 months. All Uses (reauth): 12 months
Other Criteria	All Uses (reauth): Patient demonstrates positive clinical response to therapy.

INJECTABLE TESTOSTERONE, NON-PREFERRED (S)

Products Affected

- Xyosted

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	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	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

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. 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 (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

INQOVI (S)

Products Affected

- Inqovi

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

INREBIC (S)

Products Affected

- Inrebic

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

INTRAROSA (S)

Products Affected

- Intrarosa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Dyspareunia (reauth): Patient demonstrates positive clinical response to therapy.

IQIRVO (S)

Products Affected

- Iqirvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary biliary cholangitis (PBC) (aka primary biliary cirrhosis). One of the following: A) Both of the following: 1) 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 2) Used in combination with UDCA, OR B) History of contraindication or intolerance to UDCA. Requested drug will not be used in combination with Ocaliva (obeticholic acid).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Ocaliva (obeticholic acid).

IRESSA (S)

Products Affected

- Gefitinib
- Iressa

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 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ISTURISA (S)

Products Affected

- Isturisa TABS 1MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's disease (initial, reauth): 12 months
Other Criteria	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).

ITOVEBI (S)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: a) Locally advanced, or b) Metastatic. Disease is all of the following (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]): a) PIK3CA-mutated, b) Hormone receptor (HR)-positive, c) Human epidermal growth-factor receptor 2 (HER2)-negative. Used following recurrence on or after completing adjuvant endocrine therapy (e.g. Zoladex [goserelin], Arimidex [anastrozole], Nolvadex [tamoxifen]). Used in combination with both of the following: a) Ibrance (Palbociclib), and b) Fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

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

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

IVERMECTIN (S)

Products Affected

- Ivermectin TABS
- Stromectol TABS 3MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	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	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 109/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/mm3. Continued in Other Criteria Section.
Age Restrictions	HIV (initial): patient is less than or equal to 12 years of age.
Prescriber Restrictions	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).
Coverage Duration	4 months: Solid organ transplant. 12 months: all other diagnoses.

Other Criteria	[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). [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.

IWILFIN (S)

Products Affected

- Iwilfin

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

JAKAFI (S)

Products Affected

- Jakafi

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

JATENZO (S)

Products Affected

- Jatenzo

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.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months. PKU (Reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

JOENJA (S)

Products Affected

- Joenja

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: geneticist, hematologist, or immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

JUXTAPID (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): 12 months
Other Criteria	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.

JYLAMVO (S)

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neoplastic diseases: Diagnosis of one of the following: A) acute lymphoblastic leukemia (ALL), B) mycosis fungoides (cutaneous T-cell lymphoma), or C) relapsed or refractory non-hodgkin lymphomas. Rheumatoid arthritis (RA): Diagnosis of RA. Psoriasis: Diagnosis of severe psoriasis.
Age Restrictions	N/A
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist. Psoriasis: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Neoplastic diseases, RA, Psoriasis: 12 months.
Other Criteria	Approve for continuation of prior therapy.

JYNARQUE (S)

Products Affected

- Jynarque TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Autosomal dominant polycystic kidney disease (ADPKD) (initial): Diagnosis of rapidly progressing ADPKD. 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. Patient does not have a history of significant liver impairment or injury, not including uncomplicated polycystic liver disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	CF (initial): Patient is 1 month of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 m2. 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. One of the following: 1) Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	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. One of the following: 1) Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).

KERYDIN (S)

Products Affected

- Tavaborole

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	N/A

KESIMPTA (S)

Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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]).
Age Restrictions	N/A
Prescriber Restrictions	MS (Initial, Reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (Initial, Reauth): 12 months
Other Criteria	MS (Reauth): Patient demonstrates positive clinical response to 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]).

KEVEYIS (S)

Products Affected

- Keveyis
- Ormalvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.).
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	All uses (Initial): 3 months. (Reauth): 12 months
Other Criteria	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
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. 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. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Diagnosis of active PJIA. Patient weighs at least 63 kg. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel, one formulary adalimumab product, Orencia, Rinvoq/LQ, or Xeljanz, 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).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, PMR (initial): Prescribed by or in consultation with a rheumatologist
Coverage Duration	RA, PJIA, PMR (initial): 6 months, (reauth): 12 months
Other Criteria	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. PMR (reauth): Patient demonstrates positive clinical response to therapy.

KINERET (S)

Products Affected

- Kineret

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. 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.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.
Coverage Duration	RA, NOMID (initial): 6 months, (reauth): 12 months. DIRA: 12 months.
Other Criteria	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

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

KISQALI-FEMARA PACK (S)

Products Affected

- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

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

KORLYM (S)

Products Affected

- Korlym
- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	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

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

KRAZATI (S)

Products Affected

- Krazati

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 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

KUVAN (S)

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy. Patient will continue to have blood Phe levels measured periodically during therapy.

LAZCLUZE (S)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Used as first line treatment of NSCLC. Used in combination with Rybrevant (amivantamab). Presence of 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

LEUKINE (S)

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Acute myeloid leukemia (AML): Diagnosis of AML. Patient has completed induction or consolidation chemotherapy. Age greater than or equal to 55 years. 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). 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. Diagnosis of FN. Patient is at high risk for infection-associated complications. HIV-related neutropenia (HIVN): Patient is infected with HIV, and absolute neutrophil count (ANC) less than or equal to 1000 (cells/mm^3).
Age Restrictions	BMSCT: Patient is 2 years of age or older.
Prescriber Restrictions	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.

Coverage Duration	BMSCT, AML, FN (prophylaxis, treatment):3mo or duration of tx. HIVN:6mo. ARS:1 mo.
Other Criteria	N/A

LEUPROLIDE BRAND (S)

Products Affected

- Leuprolide Acetate INJ 22.5MG

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

LIDOCAINE TOPICAL (S)

Products Affected

- Lidocaine Hydrochloride
  EXTERNAL SOLN

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

LIDODERM (S)

Products Affected

- Lidocaine PTCH 5%

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

LIDODERM BRAND (S)

Products Affected

- Lidocan
- Lidoderm
- Tridacaine II

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

LITFULO (S)

Products Affected

- Litfulo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

LIVMARLI (S)

Products Affected

- Livmarli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 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, 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 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, Welchol).
Age Restrictions	ALGS (initial): Patient is 3 months of age or older. PFIC (init): Patient is 12 months of age or older.
Prescriber Restrictions	All indications (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	ALGS (initial, reauth): 12 months. PFIC (init): 6 months, (reauth): 12 months.
Other Criteria	All indications (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score).

LODOCO (S)

Products Affected

- Lodoco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

LONSURF (S)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND One of the following: Used as a single agent or Used in combination with bevacizumab AND Patient has been previously treated with both of the following: A) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND B) anti-VEGF therapy (e.g., Avastin [bevacizumab]) AND One of the following: A) patient has RAS wild-type tumors and patient has been previously treated with one anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]) OR Patient has RAS mutant tumors. Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Patient has been previously treated with two of the following: fluropyrimidine-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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LORBRENA (S)

Products Affected

- Lorbrena

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 NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LOTRONEX (S)

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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].
Age Restrictions	Initial: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	IBS (initial): 12 weeks. IBS (reauth): 6 mo.
Other Criteria	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

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 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

LUMRYZ (S)

Products Affected

- Lumryz
- Lumryz Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.

LUPKYNIS (S)

Products Affected

- Lupkynis

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

LUPRON (S)

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 mo. Endomet:6mo. UL (anemia):3 mo (fibroids):4 mo
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy. Patient is currently younger than the appropriate time point for the onset of puberty (e.g., females younger than 11 years of age, males younger than 12 years of age).

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, or oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

MARINOL (S)

Products Affected

- Dronabinol
- Marinol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 3 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: 1) One of the following: a) Diagnosis of chronic hepatitis C (CHC), or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of CHC, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	8 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

MAYZENT (S)

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

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	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 Tafinlar (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 Tafinlar (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 Tafinlar (dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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 Tafinlar (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 Tafinlar (dabrafenib).

MEKTOVI (S)

Products Affected

- Mektovi

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

METFORMIN IR (S)

Products Affected

- Metformin Hydrochloride TABS
  625MG

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) 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA (initial): Prescribed by or in consultation with a rheuamtologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All Indications (Initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA (initial): Prescribed by or in consultation with a rheuamtologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All Indications (Initial, reauth): 12 months
Other Criteria	All Indications (reauth): Patient demonstrates positive clinical response to therapy.

METHYLTESTOSTERONE (S)

Products Affected

- Methitest

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. 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.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC: 12 mo. DP: 6 mo.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

MIGRANAL (S)

Products Affected

- Dihydroergotamine Mesylate NASAL SOLN
- Migranal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	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

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

MOUNJARO (S)

Products Affected

- Mounjaro

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.

MS INTERFERONS (NON-PREFERRED) (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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 (of a minimum 4-week supply), contraindication, or intolerance to one of the following: Avonex (interferon beta-1a) or Betaseron (interferon beta-1b), or 2) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

MS INTERFERONS (PREFERRED) (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

MULPLETA (S)

Products Affected

- Mulpleta

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

MYALEPT (S)

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy. One of the following: 1) Diabetes mellitus or insulin resistance despite insulin therapy at maximum tolerated doses OR 2) Hypertriglyceridemia.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Lipodystrophy (reauth): Patient demonstrates positive clinical response to therapy.

MYCAPSSA (S)

Products Affected

- Mycapssa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acromegaly (initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications (initial, reauth): 12 months.
Other Criteria	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.

NEMLUVIO (S)

Products Affected

- Nemluvio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prurigo Nodularis (PN) (Initial): Diagnosis of PN. Trial and failure, contraindication, or intolerance (TF/C/I) to one medium or higher potency topical corticosteroid. One of the following: a) TF/C/I to Dupixent (dupilumab), or b) For continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PN (Initial): Prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	PN (Reauth): Patient demonstrates positive clinical response to therapy.

NERLYNX (S)

Products Affected

- Nerlynx

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

NEULASTA (S)

Products Affected

- Neulasta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A

NEXAVAR (S)

Products Affected

- Nexavar
- Sorafenib Tosylate TABS

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 advanced RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC. One of the following: locally recurrent disease, or metastatic disease. Patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

NEXLETOL (S)

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous familial hypercholesterolemia (HeFH), primary hyperlipidemia, established cardiovascular disease (CVD), or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) HeFH, B) Primary hyperlipidemia, C) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR D) At 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 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 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 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) Patient has a contraindication to all statins. Patient has been receiving at least 12 weeks of generic ezetimibe therapy or patient has a contraindication or intolerance to ezetimibe.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	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).

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	Heterozygous familial hypercholesterolemia (HeFH), primary hyperlipidemia, established cardiovascular disease (CVD), or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) HeFH, B) Primary hyperlipidemia, C) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR D) At 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 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 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 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) Patient has a contraindication to all statins. Patient has been receiving at least 12 weeks of generic ezetimibe therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Patient continues to receive other lipid-lowering tx (eg statins, ezetimibe) or patient has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe).

NGENLA (S)

Products Affected

- Ngenla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	PGHD (initial): Patient is 3 years of age or older.
Prescriber Restrictions	PGHD (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	PGHD (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.

NINLARO (S)

Products Affected

- Ninlaro

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

NORTHERA (S)

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist
Coverage Duration	NOH (init): 1 month (reauth): 12 months
Other Criteria	NOH (reauth): Patient demonstrates positive clinical response to therapy.

NOURIANZ (S)

Products Affected

- Nourianz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (initial, reauth): 12 months
Other Criteria	PD (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with carbidopa/levodopa.

NOXAFIL POWDERMIX (S)

Products Affected

- Noxafil PACK

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. Patient weighs 40 kg or less.
Age Restrictions	Prophylaxis of SFI: Patient is age 2 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months.
Other Criteria	N/A

NOXAFIL SUSPENSION (S)

Products Affected

- 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Hormone-sensitive prostate cancer (HSPC): Diagnosis of HSPC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, HSPC: 12 months
Other Criteria	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	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 150cells/ml or peripheral blood eosinophil levels were greater than or equal to 300cells/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][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, Wixela Inhub[fluticasone propionate 100mcg/salmeterol 50mcg], 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, Wixela Inhub[fluticasone propionate 500mcg/salmeterol 50mcg], budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone 200mcg/vilanterol 25mcg])
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	Asthma (init): 6 mo, Asthma (reauth): 12 months. CRSwNP, EGPA, HES (init, reauth): 12 months
Other Criteria	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-PDGFRA-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.

NUEDEXTA (S)

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PBA (initial): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist.
Coverage Duration	PBA (initial/reauth): 12 months
Other Criteria	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

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

NURTEC (S)

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	All Indications (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	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 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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: 12 mo
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	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 AND Udenyca.

OCALIVA (S)

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	PBC (initial): 6 months, (reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	AR (Initial): Patient is 12 to 65 years of age
Prescriber Restrictions	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	AR (initial, reauth): 12 months
Other Criteria	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

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

OFEV (S)

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (initial): Prescribed by or in consultation with a pulmonologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (reauth): Patient demonstrates positive clinical response to therapy.

OGSIVEO (S)

Products Affected

- Ogsiveo

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

OHTUVAYRE (S)

Products Affected

- Ohtuvayre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic obstructive pulmonary disease (COPD). Patient is symptomatic despite being on at least two therapies indicated for the treatment of COPD and will continue to be treated with the therapies (e.g., long acting muscarinic antagonists [e.g., tiotropium], long-acting beta agonist [e.g., formoterol]), unless there is a contraindication or intolerance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Part B vs D determination applies. Reauth: Patient demonstrates a positive clinical response to therapy. Patient continues to be treated with at least two therapies indicated for the treatment of COPD (e.g., long acting muscarinic antagonists [e.g., tiotropium], long-acting beta agonist [e.g., formoterol]), unless there is a contraindication or intolerance.

OJEMDA (S)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

OJJAARA (S)

Products Affected

- Ojjaara

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

OLPRUVA (S)

Products Affected

- Olpruva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

OLUMIANT (S)

Products Affected

- Olumiant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for the treatment of Coronavirus Disease 2019 (COVID-19) in hospitaltized adults.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	RA Initial: Prescribed by or in consultation with a rheumatologist. AA (Initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	RA Initial: 6 months, Reauth: 12 months. AA (Initial, Reauth): 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (initial): 6 months, (reauth): 12 months.
Other Criteria	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

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

ONYDA (S)

Products Affected

- Onyda Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Patient is unable to swallow solid dosage forms (e.g., oral tablet, capsule). Trial and failure, contraindication, or intolerance to two of the following: a) generic atomoxetine, b) generic guanfacine ER, or c) generic clonidine ER.
Age Restrictions	Initial: Patient is less than 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

OPSUMIT (S)

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

OPZELURA (S)

Products Affected

- Opzelura

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. 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. AD, NV (Initial, Reauth): Not used in combination with therapeutic biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine).
Age Restrictions	AD, NV Initial: Patient is 12 years of age or older.
Prescriber Restrictions	AD Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist. NV Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	AD Initial: 12 weeks. AD Reauth: 6 months. NV Initial: 6 months. NV Reauth: 12 months.
Other Criteria	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. Opzelura will only be used for short-term and/or non-continuous chronic treatment. NV Reauth: Patient demonstrates positive clinical response to therapy.

ORENCIA SC (S)

Products Affected

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

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 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.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

ORGOVYX (S)

Products Affected

- Orgovyx

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

ORIAHNN (S)

Products Affected

- Oriahnn

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM (init, reauth-150mg): 6 mo. EM (200mg): 6 mo.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	CF (Initial): Patient is 6 years of age or older
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 12 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

ORSERDU (S)

Products Affected

- Orserdu

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

OSPHENA (S)

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Patient demonstrates positive clinical response to therapy.

OTEZLA (S)

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, OR calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	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).

OXERVATE (S)

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurotrophic keratitis (NK) (initial): Diagnosis of NK.
Age Restrictions	N/A
Prescriber Restrictions	NK (initial): Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	NK (initial): 8 weeks, (reauth): One 8-Week Approval
Other Criteria	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.

OZEMPIC (S)

Products Affected

- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) 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). Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by one of the following: FibroScan-aspartate aminotransferase (FAST), MRI-aspartate aminotransferase (MAST), or liver biopsy. Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: FibroScan, Fibrosis-4 index (FIB-4), or Magnetic Resonance Elastography (MRE).
Age Restrictions	N/A
Prescriber Restrictions	MASH (Initial): Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	12 months
Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates positive response to therapy.

PALYNZIQ (S)

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection. Chronic Hepatitis C: Diagnosis of chronic hepatitis C infection. Patient has compensated liver disease. One of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin).
Age Restrictions	N/A
Prescriber Restrictions	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
Coverage Duration	HepB, HepC: 48 wks.
Other Criteria	N/A

PEMAZYRE (S)

Products Affected

- Pemazyre

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

PENNSAID (S)

Products Affected

- Diclofenac Sodium EXTERNAL
  SOLN 1.5%, 2%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	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

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

POMALYST (S)

Products Affected

- Pomalyst

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

PONVORY (S)

Products Affected

- Ponvory
- Ponvory 14-day Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

POSACONAZOLE TABLET (S)

Products Affected

- 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	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 70 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 contraindication (e.g., age) 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/pre-treatment 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).
Age Restrictions	HeFH (Initial): Patient is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 thrombocytpenia. 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).
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	ITP(init,reauth):12mo.HepC:3mo(init),12mo(reauth).1stline SAA:6mo.RefractSAA:16wk-init,12mo-reauth
Other Criteria	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	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy: Init, Reauth: 12 mo. All other indications: Init, Reauth: 6 mo.

Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

QINLOCK (S)

Products Affected

- Qinlock

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

QUALAQUIN (S)

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used solely for the treatment or prevention of nocturnal leg cramps.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

QULIPTA (S)

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (init): 6mo. EM, CM (reauth): 12mo.
Other Criteria	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.

QUVIVIQ (S)

Products Affected

- Quviviq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance. Trial and failure, contraindication, or intolerance to Belsomra. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	ALS (reauthorization): Patient demonstrates positive response to therapy.

RAVICTI (S)

Products Affected

- Ravicti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	UCDs (initial): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
Coverage Duration	UCDs (Initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	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	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 70 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 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/pre-treatment 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).
Age Restrictions	(Initial) HeFH/HoFH: 10 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	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	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. 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. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
Other Criteria	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.

RETEVMO (S)

Products Affected

- Retevmo

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: 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). 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. 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. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Non-Small Cell Lung Cancer, MTC, Thyroid Cancer, Solid Tumors: 12 months
Other Criteria	Approve for continuation of prior therapy.

REVATIO (S)

Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

REVATIO SUSPENSION (S)

Products Affected

- Sildenafil Citrate SUSR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

REVCOVI (S)

Products Affected

- Revcovi

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

REVLIMID (S)

Products Affected

- Lenalidomide
- Revlimid

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

REYVOW (S)

Products Affected

- Reyvow

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	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

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

REZUROCK (S)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate].
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	cGVHD (initial): Prescribed by or in consultation with one of the following: hematologist, oncologist, or physician experienced in the management of transplant patients.
Coverage Duration	cGVHD (initial, reauth): 12 months
Other Criteria	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	Rheumatoid arthritis (RA)(init): Diagnosis (Dx) of moderately to severely active RA. RA,PJIA(init): Minimum (min) duration of a 3-mo(RA)/6-wk(PJIA) trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, (RA only) 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 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, PJIA, PsA, AS(init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PJIA, 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 one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus, Tacrolimus oint, or Eucrisa. One of the following: 1) TF of a min 12-wk supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent), 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).
Age Restrictions	AD (initial): Patient is 12 years of age or older
Prescriber Restrictions	RA, PJIA, 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.

Coverage Duration	RA, PJIA, PsA, AS, NRAS, CD, UC, AD (init): 6 months, (reauth): 12 months.
Other Criteria	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. 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, adalimumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (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).

RINVOQ LQ (S)

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Diagnosis of active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. Psoriatic arthritis (PsA) (init): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PJIA, PsA (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). PJIA, PsA (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	PJIA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	PJIA, PsA (init): 6 months, (reauth): 12 months.
Other Criteria	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.

RIVFLOZA (S)

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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^2).
Age Restrictions	Initial: Patient is 9 years of age or older.
Prescriber Restrictions	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.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	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.) 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 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

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

RUCONEST (S)

Products Affected

- Ruconest

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	N/A
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

RYBELSUS (S)

Products Affected

- Rybelsus

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.

RYDAPT (S)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test (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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SABRIL (S)

Products Affected

- Vigabatrin
- Vigadrone
- Vigpoder

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	IS: 1 month to 2 years of age. CPS: 2 years or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SAMSCA (S)

Products Affected

- Samsca
- Tolvaptan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

SANDOSTATIN (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	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.

SCEMBLIX (S)

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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), Tasigna (nilotinib), Iclusig (ponatinib)], OR 2) Disease is T315I mutation positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

SEROSTIM (S)

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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/m2, or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m2, or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m2. 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.
Age Restrictions	N/A
Prescriber Restrictions	Initial/Reauth: Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial: 3 months. Reauth: 6 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's disease (initial, reauth): 12 months
Other Criteria	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 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.

SIMPONI (S)

Products Affected

- Simponi

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. Used in combination with methotrexate. 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 SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq/Rinvoq LQ (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 SC, 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, Skyrizi (risankizumab-rzaa), Stelara, Rinvoq, Xeljanz/Xeljanz XR, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	UC (Initial): 12 weeks, (Reauth): 12 months. RA, AS, PsA (Initial): 6 months, (Reauth): 12 months

Other Criteria	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.

SKYCLARYS (S)

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Initial: Patient is 16 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Physiatrist (Physical Medicine and Rehabilitation Specialist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	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
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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	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. 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, 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.

SKYTROFA (S)

Products Affected

- Skytrofa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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) 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.
Age Restrictions	PGHD (initial): 1 year of age or older.
Prescriber Restrictions	PGHD (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	PGHD (initial, reauth): 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	PGHD (initial): Patient is 2.5 years of age or older.
Prescriber Restrictions	PGHD, AGHD, IGHDA (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	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) adrenocorticotropic 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a geneticist, orthopedic physician, rheumatologist, or endocrinologist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

SOMAVERT (S)

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial and reauth: 12 months
Other Criteria	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

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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Not used in combination with other potent immunosuppressants (eg, azathioprine, cyclosporine, biologic disease-modifying antirheumatic drugs [DMARDs]).
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 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. Not used in combination with other potent immunosuppressants (eg, azathioprine, cyclosporine, biologic DMARDs).

SOVALDI (S)

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 48 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

SPEVIGO (S)

Products Affected

- Spevigo INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized pustular psoriasis (GPP) as defined by both of the following: 1) Primary, sterile, macroscopically visible pustules on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques), AND 2) Disease is relapsing (greater than 1 episode) or persistent (greater than 3 months). Subcutaneous formulation will not be used to treat GPP flare. Patient weighs at least 40kg.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

SPRYCEL (S)

Products Affected

- Dasatinib
- Sprycel

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

STELARA (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). 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.
Age Restrictions	Plaque psoriasis, PsA: Patient is 6 years of age or older.
Prescriber Restrictions	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.
Coverage Duration	All uses (Initial): 6 months. All uses (reauth): 12 months
Other Criteria	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 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. 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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	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 AND Udenyca.

STIVARGA (S)

Products Affected

- Stivarga

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

SUNOSI (S)

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy (initial): 6 mo, (reauth): 12 mo. OSA (initial, reauth): 6 mo.
Other Criteria	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

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

SYMDEKO (S)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	Initial: Patient is 6 years of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	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

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 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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).

SYPRINE (S)

Products Affected

- Trientine Hydrochloride

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

TABRECTA (S)

Products Affected

- Tabrecta

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

TADLIQ (S)

Products Affected

- Tadliq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

TAFAMIDIS (S)

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): 12 months
Other Criteria	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	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) .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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).

TAGRISSO (S)

Products Affected

- Tagrisso

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): 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

TAKHZYRO (S)

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): 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.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 2 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

TALTZ (S)

Products Affected

- Taltz

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. 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 SC, Enbrel, one formulary adalimumab product, Orencia (abatacept), Otezla, Skyrizi, Stelara, Rinvoq/LQ (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 SC, 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) TF/C/I to Cosentyx SC and Rinvoq, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	Initial: 6 months, reauth: 12 months

Other Criteria	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 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.

TALZENNA (S)

Products Affected

- Talzenna

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

TARCEVA (S)

Products Affected

- Erlotinib Hydrochloride TABS

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 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.

TARGRETIN (S)

Products Affected

- Bexarotene

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

TARPEYO (S)

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk for disease progression (e.g., generally a proteinuria greater than 0.75 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool). Used to reduce the loss of kidney function. Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m2. 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).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	9 months.
Other Criteria	N/A

TASCENSO (S)

Products Affected

- Tascenso Odt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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.
Age Restrictions	MS (initial): Patient is 10 years of age or older.
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

TASIGNA (S)

Products Affected

- Tasigna

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

TAVALISSE (S)

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic 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.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP (initial, reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	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

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

TECFIDERA (S)

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack
  CDPK 0

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

TEPMETKO (S)

Products Affected

- Tepmetko

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 NSCLC. Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	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
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. 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.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GD: 12 mo. DP: 6 mo.
Other Criteria	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 CAPS 100MG, 50MG

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

TIBSOVO (S)

Products Affected

- Tibsovo

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

TIGLUTIK (S)

Products Affected

- Teglutik

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

TORPENZ (S)

Products Affected

- Torpenz

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.

TRACLEER (S)

Products Affected

- Bosentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

TRELSTAR (S)

Products Affected

- Trelstar Mixject

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

TREMFYA (S)

Products Affected

- Tremfya INJ 100MG/ML

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. 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 SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab), Stelara (ustekinumab), Rinvoq/LQ (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All Indications (Initial): 6 months, (reauth): 12 months
Other Criteria	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. 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. 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.

TRIKAFTA (S)

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	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.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).

TRULICITY (S)

Products Affected

- 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.

TRUQAP (S)

Products Affected

- Truqap TABS

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

TUKYSA (S)

Products Affected

- Tukysa

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

TURALIO (S)

Products Affected

- Turalio CAPS 125MG

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

TYENNE SC (S)

Products Affected

- Tyenne INJ 162MG/0.9ML

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. 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. 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, Orencia (abatacept), Rinvoq/LQ, 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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months

Other Criteria	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.

TYKERB (S)

Products Affected

- Lapatinib Ditosylate

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

TYMLOS (S)

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (max 24 months of therapy per lifetime)
Other Criteria	N/A

TYVASO DPI (S)

Products Affected

- Tyvaso Dpi Maintenance Kit POWD 16MCG, 32MCG, 48MCG, 64MCG
- Tyvaso Dpi Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	PAH, PH-ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, PH-ILD: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, PH-ILD (Reauth): Patient demonstrates positive clinical response to therapy.

UBRELVY (S)

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	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 CGRP inhibitor for the acute treatment of migraines.

UDENYCA (S)

Products Affected

- Udenyca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A

UPTRAVI (S)

Products Affected

- Uptravi TABS
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

VALCHLOR (S)

Products Affected

- Valchlor

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

VANFLYTA (S)

Products Affected

- Vanflyta

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

VELSIPITY (S)

Products Affected

- Velsipity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib/ER), OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (initial): 6 months, (reauth): 12 months.
Other Criteria	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

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

VEOZAH (S)

Products Affected

- Veozah

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

VERQUVO (S)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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].
Age Restrictions	N/A
Prescriber Restrictions	CHF (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CHF (initial, reauth): 12 months
Other Criteria	CHF (reauth): Patient demonstrates positive clinical response to therapy.

VERZENIO (S)

Products Affected

- Verzenio

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

VEVYE (S)

Products Affected

- Vevye

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

VIBERZI (S)

Products Affected

- Viberzi

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

VICTOZA (S)

Products Affected

- Liraglutide INJ 18MG/3ML
- Victoza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) 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. Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by one of the following: FibroScan-aspartate aminotransferase (FAST), MRI-aspartate aminotransferase (MAST), or liver biopsy. Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: FibroScan, Fibrosis-4 index (FIB-4), or Magnetic Resonance Elastography (MRE).
Age Restrictions	N/A
Prescriber Restrictions	MASH (Initial): Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	12 months
Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates positive response to therapy.

VIGAFYDE (S)

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial and failure, or intolerance to generic vigabatrin.
Age Restrictions	Patient is 1 month to 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VIJOICE (S)

Products Affected

- Vijoice

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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]).
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a physician who specializes in the treatment of PROS.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

VITRAKVI (S)

Products Affected

- Vitrakvi

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

VIZIMPRO (S)

Products Affected

- Vizimpro

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 NSCLC. Disease is metastatic. Disease is positive for one of the following epidermal growth factor receptor (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): exon 19 deletion or exon 21 L858R substitution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VONJO (S)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VOQUEZNA (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	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 infecion. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	H. pylori, NERD: 1 mo. HRH: 8 wks. MHRH: 6 mos.

Other Criteria	Relief of Heartburn associated with Non-Erosive Gastroesophageal Reflux Disease (NERD): Diagnosis of non-erosive Gastroesophageal Reflux Disease. Both of the following: a) Patient has history of heartburn for at least 6 months and b) Heartburn symptoms are present for at least 4 days during any consecutive 7-day period. 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.

VORANIGO (S)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of astrocytoma or oligodendroglioma. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

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 Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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].
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

VOTRIENT (S)

Products Affected

- Pazopanib Hydrochloride
- Votrient

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 advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

VOWST (S)

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 Dificid (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).
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A

VOXZOGO (S)

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a clinical geneticist, endocrinologist, or a physician who has specialized expertise in the management of achondroplasia.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus), 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).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of presbyopia.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Initial: 3 months. Reauth: 6 months.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.

VYVANSE (S)

Products Affected

- Lisdexamfetamine Dimesylate
- Vyvanse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 both of the following: a) patient has had BED for 3 months or longer, AND b) 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.
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	ADHD, ADD: 12 months, BED (initial): 3 months, (reauthorization): 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to have a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, 2) Patient continues to have a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130, or 3) Patient continues to have a baseline Karnofsky Performance Status score greater than 50%.

WAKIX (S)

Products Affected

- Wakix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 (e.g., not indicated for patient's age) or intolerance to both generic modafinil and generic armodafinil.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	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). BMI greater than or equal to 27 kg/m2. 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. 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Acne (initial): Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Acne (initial): 6 months. Acne (reauth): 12 months.
Other Criteria	Acne (reauth): Patient demonstrates positive clinical response to therapy.

WINREVAIR (S)

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. Patient is currently on at least two therapies indicated for the treatment of PAH from the following different mechanisms of action, unless there is a contraindication or intolerance: a) Endopthelin receptor antagonists (ie, Bosentan, ambrisentan or macitentan) and b) Phosphodiesterase 5 inhibitors (ie, Tadalafil or sildenafil).
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

XALKORI (S)

Products Affected

- Xalkori

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 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).
Age Restrictions	IMT, ALCL: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XATMEP (S)

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL). Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of active polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	ALL, pJIA: 12 months.
Other Criteria	Approve for continuation of prior therapy.

XCOPRI (S)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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	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).
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.
Coverage Duration	RA/PJIA/PsA/AS (initial): 6 mo, (reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.
Other Criteria	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).

XENAZINE (S)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	All uses: (initial) 3 months. (Reauth) 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

XERMELO (S)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MM/BMST, GCTB: 12 mo. HCM: 2 mo.
Other Criteria	GCTB: Approve for continuation of prior therapy.

XIFAXAN (S)

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TD: 14 days. HE (tx): 12 months. HE (ppx) (init, reauth): 12 months. IBS-D (init, reauth): 2 weeks.
Other Criteria	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	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, Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], 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, Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/ formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	IgE-Mediated Food Allergy (init): Patient is 1 year of age or older.
Prescriber Restrictions	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.

Coverage Duration	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.

XOLREMDI (S)

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Patient has genotype confirmed variant of CXCR4 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells/µL.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: immunologist, hematologist, geneticist, dermatologist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

XOSPATA (S)

Products Affected

- Xospata

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

XPOVIO (S)

Products Affected

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

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

XTANDI (S)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic castration-sensitive prostate cancer. Non-metastatic castrion-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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XYREM (S)

Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	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

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

ZAVESCA (S)

Products Affected

- Miglustat
- Yargesa

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

ZEJULA (S)

Products Affected

- Zejula 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZELBORAF (S)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All indications: Approve for continuation of therapy.

ZEPATIER (S)

Products Affected

- Zepatier

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	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.
Coverage Duration	12 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

ZEPOSIA (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz IR (tofacitinib IR)/Xeljanz XR (tofacitinib XR), OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist. UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (initial, reauth): 12 months. UC (init): 6 months, (reauth): 12 months.
Other Criteria	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
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	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 AND Udenyca.

ZILBRYSQ (S)

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

ZOLINZA (S)

Products Affected

- Zolinza

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

ZORYVE (S)

Products Affected

- Zoryve CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus), 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).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial: 6 months, Reauth: 12 months.
Other Criteria	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZTLIDO (S)

Products Affected

- Ztlido

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

ZURZUVAE (S)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	PPD: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy.

ZYDELIG (S)

Products Affected

- Zydelig

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

ZYKADIA (S)

Products Affected

- Zykadia TABS

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 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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

ZYTIGA (PREFERRED) (S)

Products Affected

- Abiraterone Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, CSPC: 12 months
Other Criteria	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
- Myhibbin
- Nebupent
- Neoral
- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- 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 TABS 1MG, 2MG
- Recombivax Hb
- Sandimmune CAPS 100MG, 25MG
- 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.

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