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## Medicare Plus Blue<sup>SM</sup> PPO Essential, Medicare Plus Blue<sup>SM</sup> PPO + Meijer, and Medicare Plus Blue<sup>SM</sup> PPO + Part B Credit Core Comprehensive Formulary Prior Authorization / Step Therapy Program 2025 Plan Year

BCBSM – Medicare Plus Blue PPO Essential, Medicare Plus Blue PPO + Meijer, and Medicare Plus Blue PPO + Part B Credit monitor the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization** (PA) for these drugs means that either clinical and/or administrative criteria must be met before coverage is provided. Drugs subject to **step therapy** (ST) may require previous treatment with one or more formulary drugs prior to coverage. Drugs that must meet clinical/administrative criteria are identified in the formulary list with (PA) or (ST). Medications that require PA or ST are listed below. Drugs with PA criteria are listed first followed by drugs with ST criteria. Please refer to the Formulary to verify if your drugs are covered. Your physician can contact our pharmacy help desk to request prior authorization or step therapy for these drugs.

The clinical criteria for authorization are based on current medical information and the recommendations of the Blues' Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts.

Please call the customer service number on the back of your Blue Cross member ID card if you have questions about your drug coverage or a drug claim.

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Formulary ID: 25351, Version: 8, Effective Date: 01/01/2025

Last Updated: 09/18/2024

## ACITRETIN

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### Products Affected

- Acitretin

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

## ACTIMMUNE

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### Products Affected

- Actimmune INJ 100MCG/0.5ML

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

## ADEMPAS

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### Products Affected

- Adempas

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

## ADLARITY

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### Products Affected

- Adlarity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF GENERIC ORAL DONEPEZIL.

## AFINITOR

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### Products Affected

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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER REQUIRES COMBINATION USE WITH EXEMESTANE AND A TRIAL OF LETROZOLE OR ANASTROZOLE. COVERAGE FOR THE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRES A TRIAL OF SUNITINIB OR SORAFENIB.

## AFINITOR DISPERZ

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### Products Affected

- Everolimus TBSO

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

# AIMOVIG

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## Products Affected

- Aimovig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE).



# AKEEGA

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**Products Affected**

- Akeega

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS BRCA-MUTATED (BRCAM) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES COMBINATION USE WITH PREDNISONE.

## ALECENSA

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### Products Affected

- Alecensa

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

## ALOSETRON

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### Products Affected

- Alosetron Hydrochloride

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

## ALPHA-1-PROTEINASE INHIBITORS

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### Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PATIENTS MUST HAVE A DIAGNOSIS OF NECROTIZING PANNICULITIS OR ALPHA-1 ANTITRYPSIN DEFICIENCY WITH AN FEV1 LESS THAN 80% PREDICTED.
<b>Age Restrictions</b>	PATIENTS 18 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	DOCUMENTATION OF A CONGENITAL DEFICIENCY OF ALPHA-1 ANTITRYPSIN, DEMONSTRATED BY A HOMOZYGOUS PHENOTYPE OF AAT, AND MUST HAVE SYMPTOMATIC EMPHYSEMA.

# ALUNBRIG

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**Products Affected**

- Alunbrig TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES A TRIAL OF CRIZOTINIB.

# APTIOM

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## Products Affected

- Aptiom

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# ARCALYST

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## Products Affected

- Arcalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF RECURRENT PERICARDITIS REQUIRES A TRIAL OF A NONSTEROIDAL ANTI-INFLAMMATORY DRUG IN COMBINATION WITH COLCHICINE.

## ARIKAYCE

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### Products Affected

- Arikayce

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



## AUBAGIO

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### Products Affected

- Teriflunomide

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

## AUGTYRO

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### Products Affected

- Augtyro

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

# AUVELITY

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## Products Affected

- Auvelity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF BUPROPION AND ONE OTHER GENERIC FORMULARY ANTIDEPRESSANT

# AVONEX

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## Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF BETASERON

## AYVAKIT

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### Products Affected

- Ayvakit

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

## BALVERSA

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### Products Affected

- Balversa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CARCINOMA (MUC) WITH SUSCEPTIBLE FGFR3 GENETIC ALTERATIONS REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

## BANZEL

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### Products Affected

- Rufinamide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF DIVALPROEX OR VALPROIC ACID, AND LAMOTRIGINE

## BENLYSTA

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### Products Affected

- Benlysta INJ 200MG/ML

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



## BESREMI

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### Products Affected

- Besremi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF HYDROXYUREA AND PEGINTERFERON ALPHA-2A

## BETASERON

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### Products Affected

- Betaseron

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

## BOSULIF

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### Products Affected

- Bosulif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ACCELERATED, OR BLAST PHASE PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY.

# BRAFTOVI

## 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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB. COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER (CRC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH CETUXIMAB. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB.

# BRIVIACT

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## Products Affected

- Briviact SOLN
- Briviact TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF LEVETIRACETAM AND ONE OTHER FORMULARY GENERIC ANTICONVULSANT

## BRONCHITOL

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### Products Affected

- Bronchitol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION THAT THE MEMBER HAS PASSED THE BRONCHITOL TOLERANCE TEST.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# BRUKINSA

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## Products Affected

- Brukinsa

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF AT LEAST ONE PRIOR THERAPY. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY MARGINAL ZONE LYMPHOMA (MZL) REQUIRES A TRIAL OF AT LEAST ONE ANTI-CD20-BASED REGIMEN. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA (FL) REQUIRES COMBINATION USE WITH OBINUTUZUMAB AND A TRIAL OF TWO OR MORE LINES OF SYSTEMIC THERAPY.

# CABLIVI

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## Products Affected

- Cablivi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP) REQUIRES COMBINATION USE WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY.



# CABOMETYX

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## Products Affected

- Cabometyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA REQUIRES COMBINATION USE WITH NIVOLUMAB. COVERAGE FOR THE TREATMENT OF HEPATOCELLULAR CARCINOMA (HCC) REQUIRES A TRIAL OF SORAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC DIFFERENTIATED THYROID CANCER (DTC) THAT IS RADIOACTIVE IODINE-REFRACTORY OR INELIGIBLE REQUIRES A TRIAL OF VEGFR-TARGETED THERAPY.

## CALCIPOTRIENE

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### Products Affected

- Calcipotriene CREA
- Calcipotriene SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	REQUIRES TRIAL OF AT LEAST ONE GENERIC TOPICAL STEROID.

## CALQUENCE

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### Products Affected

- Calquence

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF AT LEAST ONE PRIOR THERAPY.

## CAPRELSA

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### Products Affected

- Caprelsa

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

# CAYSTON

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## Products Affected

- Cayston

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

## CERDELGA

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### Products Affected

- Cerdelga

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

# CIALIS

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## Products Affected

- Tadalafil TABS 2.5MG, 5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES THE DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	N/A

## CLOMIPHENE

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### Products Affected

- Clomid

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



# COMETRIQ

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## Products Affected

- Cometriq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A

# COPAXONE

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## Products Affected

- Glatiramer Acetate
- Glatopa

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

## COPIKTRA

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### Products Affected

- Copiktra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL) REQUIRES A TRIAL OF AT LEAST TWO PRIOR THERAPIES.

## COSENTYX

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### Products Affected

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

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (AXSPA) REQUIRES A DIAGNOSIS OF NON-RADIOGRAPHIC AXSPA AND OBJECTIVE SIGNS OF INFLAMMATION. COVERAGE FOR NON-RADIOGRAPHIC AXSPA ALSO REQUIRES THE TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ENTHESITIS-RELATED ARTHRITIS (ERA) REQUIRES A DIAGNOSIS OF ACTIVE ERA AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>

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# COTELLIC

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## Products Affected

- Cotellic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH VEMURAFENIB.

# CYSTARAN

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## Products Affected

- Cystaran

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

## DALFAMPRIDINE

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### Products Affected

- Dalfampridine Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	EXCLUDED FOR USE IF PATIENT IS WHEEL-CHAIR BOUND OR BECOMES WHEEL-CHAIR BOUND
<b>Required Medical Information</b>	SUBMISSION OF TIMED 25-FOOT WALK TEST
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF MULTIPLE SCLEROSIS (MS) REQUIRES DOCUMENTATION OF A BASELINE TIMED 25-FOOT WALK (T25FW) TEST PRIOR TO INITIATION. REAUTHORIZATION REQUIRES DOCUMENTATION OF STABILITY ON T25FW TEST OR IMPROVEMENT ON T25FW TEST



## DALIRESP

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### Products Affected

- Roflumilast

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	ONE YEAR
<b>Other Criteria</b>	A. Coverage is provided for the treatment of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis in patients with a history of exacerbations. B. Patient is receiving: inhaled long-acting beta-2 agonist [for example, formoterol, salmeterol] AND at least one additional therapy from the following categories: inhaled long-acting anticholinergic agent [for example, tiotropium] OR inhaled corticosteroid [for example, fluticasone] OR If patient experienced intolerance or has contraindications to use of these medications.

## DAURISMO

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### Products Affected

- Daurismo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) REQUIRES COMBINATION USE WITH LOW-DOSE CYTARABINE.

# DIACOMIT

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## Products Affected

- Diacomit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS. COVERAGE FOR THE TREATMENT OF SEIZURES ASSOCIATED WITH DRAVET SYNDROME REQUIRES COMBINATION USE WITH CLOBAZAM.

## DIHYDROERGOTAMINE NASAL SPRAY

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### Products Affected

- Dihydroergotamine Mesylate SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF TWO TRIPTANS ON THE FORMULARY: ONE ORAL TRIPTAN AND ONE NON-ORAL TRIPTAN (SUCH AS NASAL SPRAY OR INJECTION).

## DRIZALMA SPRINKLE

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### Products Affected

- Drizalma Sprinkle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## DULERA

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### Products Affected

- Dulera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR ASTHMA REQUIRES A DIAGNOSIS OF ASTHMA AND TRIAL OF ONE OF THE FOLLOWING: 1. BREO ELLIPTA OR 2. ADVAIR HFA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

## DUPIXENT

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### Products Affected

- Dupixent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

# EMGALITY

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## Products Affected

- Emgality

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE).



## EMSAM

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### Products Affected

- Emsam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL WITH TWO OF THE FOLLOWING: MARPLAN, PHENELZINE, TRANYLCPROMINE

## **ENBREL**

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### **Products Affected**

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR JUVENILE PSORIATIC ARTHRITIS (JPSA) REQUIRES A DIAGNOSIS OF ACTIVE JPSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>

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## ENDARI

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### Products Affected

- Endari
- L-glutamine PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PATIENT HAS EXPERIENCED 2 OR MORE SICKLE CELL-RELATED CRISES IN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	REQUIRES THE TRIAL OF OR INTOLERANCE TO HYDROXYUREA.

# ENHERTU

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## Products Affected

- Enhertu

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR HER2-POSITIVE (IHC 3+ OR ISH+) BREAST CANCER REQUIRES PRIOR ANTI-HER2 BASED TREATMENT EITHER IN THE NEOADJUVANT/ADJUVANT SETTING WITH DISEASE RECURRENCE DURING OR WITHIN 6 MONTHS OF COMPLETING THERAPY OR IN THE METASTATIC SETTING. COVERAGE FOR HER2-LOW (IHC 1+ OR IHC 2+/ISH-) BREAST CANCER REQUIRES PRIOR CHEMOTHERAPY IN THE METASTATIC SETTING OR DISEASE RECURRENCE DURING OR WITHIN 6 MONTHS OF COMPLETING ADJUVANT CHEMOTHERAPY. COVERAGE FOR NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE ACTIVATING HER2 (ERBB2) MUTATIONS REQUIRES PRIOR SYSTEMIC THERAPY. COVERAGE FOR HER2-POSITIVE (IHC 3+ OR IHC 2+/ISH+) GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA REQUIRES PRIOR TRASTUZUMAB-BASED TREATMENT. COVERAGE FOR HER2-POSITIVE (IHC 3+) SOLID TUMORS REQUIRES PRIOR SYSTEMIC TREATMENT.</p>

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## EPCLUSA

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### Products Affected

- Epclusa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

# EPIDIOLEX

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## Products Affected

- Epidiolex

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF LENNOX-GASTAUT SYNDROME REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES. COVERAGE FOR A DIAGNOSIS OF DRAVET SYNDROME REQUIRES A TRIAL OF 2 OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, OR TOPIRAMATE. COVERAGE FOR TREATMENT OF SEIZURES ASSOCIATED WITH TUBEROUS SCLEROSIS COMPLEX REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES.

# EPRONTIA

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## Products Affected

- Eprontia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE PREVENTATIVE TREATMENT OF MIGRAINE REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ALTERNATIVES FOR MIGRAINE PREVENTION, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES. COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER/EPILEPSY REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES



## ERIVEDGE

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### Products Affected

- Erivedge

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST OR DERMATOLOGIST
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ERLEADA

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### Products Affected

- Erleada

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

## ERYTHROPOIESIS STIMULATING AGENTS

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### Products Affected

- Procrit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	THREE MONTHS
<b>Other Criteria</b>	ERYTHROPOIESIS STIMULATING AGENTS ARE SUBJECT TO PART B VS PART D REVIEW.

## ESBRIET

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### Products Affected

- Pirfenidone CAPS
- Pirfenidone TABS 267MG, 801MG

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

## EULEXIN

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### Products Affected

- Eulexin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF GENERIC BICALUTAMIDE.

## EXKIVITY

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### Products Affected

- Exkivity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATIONS WITH DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY.

## FANAPT

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### Products Affected

- Fanapt
- Fanapt Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF TWO GENERIC FORMULARY ATYPICAL ANTIPSYCHOTICS (E.G., ARIPIRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE)

## FASENRA

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### Products Affected

- Fasenra
- Fasenra Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



# FETZIMA

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## Products Affected

- Fetzima
- Fetzima Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF VENLAFAXINE (OR DESVENLAFAXINE) AND DULOXETINE

# FINTEPLA

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## Products Affected

- Fintepla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF TWO OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, TOPIRAMATE.

# FIRAZYR

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## Products Affected

- Icatibant Acetate
- Sajazir

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## FOTIVDA

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### Products Affected

- Fotivda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ADVANCED RENAL CELL CARCINOMA REQUIRES A TRIAL OF TWO OR MORE PRIOR SYSTEMIC THERAPIES.

# FRUZAQLA

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## Products Affected

- Fruzaqla

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR METASTATIC COLORECTAL CANCER (mCRC) REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METASTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY

## FYCOMPA

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### Products Affected

- Fycompa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# GATTEX

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## Products Affected

- Gattex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION OF DEPENDENCE ON PARENTERAL SUPPORT FOR 12 MONTHS OR GREATER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# GAVRETO

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## Products Affected

- Gavreto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ADVANCED OR METASTATIC RET FUSION-POSITIVE THYROID CANCER THAT REQUIRES SYSTEMIC THERAPY AND RADIOACTIVE IODINE-REFRACTORY (IF RADIOACTIVE IODINE IS APPROPRIATE).



# GILENYA

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## Products Affected

- Fingolimod Hydrochloride

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

# GILOTRIF

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## Products Affected

- Gilotrif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## GLP-1 AGONISTS

### Products Affected

- Bydureon Bcise
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	EXCLUDED IF USED FOR THE TREATMENT OF WEIGHT LOSS ONLY.
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## GROWTH HORMONE

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### Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PEDIATRIC PATIENTS REQUIRES FOR ALL INDICATIONS MUST BE PRESCRIBED BY AN ENDOCRINOLOGIST OR NEPHROLOGIST.
<b>Coverage Duration</b>	PEDIATRICS EQUALS ONE YEAR. ADULTS EQUALS LIFETIME
<b>Other Criteria</b>	N/A

## HAEGARDA

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### Products Affected

- Haegarda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	6 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# HARVONI

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## Products Affected

- Harvoni

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

# HETLIOZ

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## Products Affected

- Tasimelteon

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

## **HIGH RISK MEDICATIONS**

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## Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 100MG, 10MG, 50MG
- Benztropine Mesylate TABS
- Chlorpromazine Hcl TABS
- Chlorpromazine Hydrochloride CONC
- Chlorpromazine Hydrochloride TABS
- Clozapine TABS 100MG, 200MG, 25MG, 50MG
- Clozapine Odt
- Compro
- Cyclobenzaprine Hydrochloride TABS 10MG, 5MG
- Dicyclomine Hydrochloride CAPS
- Dicyclomine Hydrochloride TABS
- Diphenoxylate Hydrochloride/atropine Sulfate
- Diphenoxylate/atropine LIQD
- Doxepin Hcl CAPS 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 100MG, 10MG, 150MG, 25MG, 50MG
- Hydroxyzine Hcl TABS 50MG
- Hydroxyzine Hydrochloride TABS 10MG, 25MG
- Hydroxyzine Pamoate CAPS 25MG, 50MG
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Meclizine Hcl TABS
- Nortriptyline Hcl CAPS 25MG, 75MG
- Nortriptyline Hcl SOLN
- Nortriptyline Hydrochloride CAPS 10MG, 50MG
- Olanzapine TABS
- Olanzapine Odt

## Prior Authorization Criteria

- Oxybutynin Chloride SOLN
- Oxybutynin Chloride TABS 5MG
- Oxybutynin Chloride Er
- Paroxetine Hcl TABS 30MG, 40MG
- Paroxetine Hydrochloride SUSP
- Paroxetine Hydrochloride TABS 10MG, 20MG
- Perphenazine TABS
- Prochlorperazine SUPP 25MG
- Prochlorperazine Maleate TABS
- Promethazine Hcl TABS 12.5MG
- Promethazine Hydrochloride TABS 25MG, 50MG
- Solifenacin Succinate
- Tolterodine Tartrate
- Tolterodine Tartrate Er
- Trihexyphenidyl Hydrochloride
- Versacloz

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES ALL OF THE FOLLOWING: 1) PRESCRIBER CONSIDERATION OF THERAPY MODIFICATION WHEN USING ANTICHOLINERGIC DRUGS IN COMBINATION, 2) PRESCRIBER ACKNOWLEDGEMENT OF SAFETY RISKS (E.G., CONFUSION, DRY MOUTH, BLURRY VISION, CONSTIPATION, URINARY RETENTION, INCREASED RISK OF DEMENTIA), 3) PRESCRIBER AND PATIENT HAVE DISCUSSED THE ABOVE RISKS. PRIOR AUTHORIZATION APPLIES ONLY TO PATIENTS 65 YEARS OF AGE OR OLDER.

## **HUMIRA**

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### **Products Affected**

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

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR CROHN’S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE,</p>

Formulary ID: 25351, Version: 8, Effective Date: 01/01/2025

Last Updated: 09/18/2024

Prior Authorization Criteria

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	<p>METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX/TREXALL). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (6-MP), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), DIPENTUM (OLSALAZINE), AZULFIDINE (SULFASALAZINE)], IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE). COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. COVERAGE FOR UVEITIS REQUIRES A DIAGNOSIS OF NON-INFECTIOUS UVEITIS CLASSIFIED AS ONE OF THE FOLLOWING: INTERMEDIATE, POSTERIOR, PANUVEITIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>
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## HUMULIN R U-500

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### Products Affected

- Humulin R U-500 (concentrated)
- Humulin R U-500 Kwikpen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF HUMULIN R AND THE PATIENT REQUIRES AT LEAST 200 UNITS PER DAY OF HUMULIN R

# IBRANCE

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## Products Affected

- Ibrance

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT IN PATIENTS WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY.



# ICLUSIG

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## Products Affected

- Iclusig

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED PHILADELPHIA CHROMOSOME-POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ ALL) REQUIRES COMBINATION USE WITH CHEMOTHERAPY. COVERAGE FOR THE TREATMENT OF CHRONIC PHASE (CP) CHRONIC MYELOID LEUKEMIA (CML) REQUIRES THE TRIAL AT LEAST TWO PRIOR KINASE INHIBITORS.

## IDHIFA

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### Products Affected

- Idhifa

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

# IMBRUVICA

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## Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 420MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF CHRONIC GRAFT VERSUS HOST DISEASE REQUIRE A TRIAL OF ONE OR MORE LINES OF SYSTEMIC THERAPY.

## IMMUNE GLOBULIN (IVIG) PRODUCTS

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### Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c

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	1 YEAR
Other Criteria	IMMUNE GLOBULIN (IVIG) PRODUCTS ARE SUBJECT TO PART B VS PART D REVIEW.

# INCRELEX

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## Products Affected

- Increlex

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

# INLYTA

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## Products Affected

- Inlyta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRE COMBINATION USE WITH AVELUMAB OR PEMBROLIZUMAB. COVERAGE FOR TREATMENT OF ADVANCED CELL CARCINOMA (RCC) REQUIRES A TRIAL OF ONE PRIOR SYSTEMIC THERAPY.

# INQOVI

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## Products Affected

- Inqovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## INREBIC

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### Products Affected

- Inrebic

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



## IRESSA

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### Products Affected

- Gefitinib

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

## ISOTRETINOIN

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### Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Zenatane

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF EITHER AN ORAL ANTIBIOTIC OR A BENZOYL PEROXIDE CONTAINING TOPICAL THERAPY.

## IVERMECTIN

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### Products Affected

- Ivermectin TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## IWILFIN

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### Products Affected

- Iwilfin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF HIGH-RISK NEUROBLASTOMA (HRNB) WHO HAVE DEMONSTRATED AT LEAST A PARTIAL RESPONSE TO PRIOR MULTAGENT, MULTIMODALITY THERAPY INCLUDING ANTI-GD2 IMMUNOTHERAPY.

## JADENU

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### Products Affected

- Deferasirox TABS

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

# JAKAFI

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## Products Affected

- Jakafi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST, HEMATOLOGIST, OR TRANSPLANT SPECIALIST.
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF POLYCYTHEMIA VERA THAT DEMONSTRATED AN INADEQUATE RESPONSE OR ARE INTOLERANT TO HYDROXYUREA. COVERAGE FOR THE TREATMENT OF CHRONIC VERSUS HOST DISEASE REQUIRES A TRIAL OF ONE OR TWO LINES OF SYSTEMIC THERAPY

# JAYPIRCA

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## Products Affected

- Jaypirca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF TWO LINES OF SYSTEMIC THERAPY (INCLUDING A BTK INHIBITOR). COVERAGE FOR CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LYMPHOMA (CLL/SLL) REQUIRES A TRIAL OF TWO PRIOR LINES OF SYSTEMIC THERAPY (INCLUDING A BTK INHIBITOR AND A BCL-2 INHIBITOR).

# JOENJA

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## Products Affected

- Joenja

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	FOR TREATMENT OF ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS): CANNOT BE USED IN COMBINATION WITH AN IMMUNOSUPPRESSIVE MEDICATION.
<b>Required Medical Information</b>	COVERAGE FOR ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS) REQUIRES ALL OF THE FOLLOWING: 1. A DIAGNOSIS OF APDS WITH AN ASSOCIATED PI3Kδ MUTATION, 2. DOCUMENTED VARIANT IN EITHER PIK3CD OR PIK3R1, AND 3. DOCUMENTED SYMPTOMS ASSOCIATED WITH APDS SUCH AS NODAL AND/OR EXTRANODAL LYMPHOPROLIFERATION, HISTORY OF REPEATED OTO-SINO-PULMONARY INFECTIONS AND/OR ORGAN DYSFUNCTION (E.G. LUNG, LIVER).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# JYLAMVO

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## Products Affected

- Jylamvo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF METHOTREXATE TABLET, OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL TABLET FORMULATION OF METHOTREXATE

## KALYDECO

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### Products Affected

- Kalydeco

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

## KERENDIA

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### Products Affected

- Kerendia

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

# KETOCONAZOLE

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## Products Affected

- Ketoconazole TABS

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

# KEVZARA

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## Products Affected

- Kevzara

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, HUMIRA, RINVOQ, XELJANZ/XR, ORENCIA. COVERAGE FOR POLYMYALGIA RHEUMATICA (PMR) REQUIRES BOTH OF THE FOLLOWING: 1) HISTORY OF TREATMENT WITH CORTICOSTEROIDS AT A DOSE OF GREATER THAN 10 MG PER DAY PREDNISONE EQUIVALENT FOR AT LEAST 8 WEEKS AND 2) INADEQUATE RESPONSE OR INTOLERANCE TO CORTICOSTEROIDS AS DEMONSTRATED BY A DISEASE FLARE DURING CORTICOSTEROID TAPER AT A DOSE OF GREATER THAN 7.5 MG PER DAY PREDNISONE EQUIVALENT. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# KINERET

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## Products Affected

- Kineret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, HUMIRA, RINVOQ, XELJANZ/XR, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# KISQALI

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT AS INITIAL ENDOCRINE BASED THERAPY OR FOLLOWING DISEASE PROGRESSION ON ENDOCRINE THERAPY.

# KORLYM

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## Products Affected

- Mifepristone TABS 300MG

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



# KOSELUGO

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## Products Affected

- Koselugo

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

# KRAZATI

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## Products Affected

- Krazati

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

# LENVIMA

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## 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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	<p>COVERAGE FOR RENAL CELL CARCINOMA (RCC) AS FIRST LINE THERAPY REQUIRES COMBINATION USE WITH PEMBROLIZUMAB. COVERAGE FOR RENAL CELL CARCINOMA (RCC) REQUIRES COMBINATION USE WITH EVEROLIMUS FOLLOWING ONE PRIOR ANTI-ANGIOGENIC THERAPY. COVERAGE FOR ADVANCED ENDOMETRIAL CARCINOMA (EC) REQUIRES COMBINATION USE WITH PEMBROLIZUMAB WHO HAVE DISEASE PROGRESSION FOLLOWING PRIOR SYSTEMIC THERAPY.</p>

# LEUPROLIDE

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## Products Affected

- Leuprolide Acetate INJ  
1MG/0.2ML, 22.5MG
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)

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

# LIBERVANT

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## Products Affected

- Libervant

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

# LIBTAYO

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## Products Affected

- Libtayo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR BASAL CELL CARCINOMA (BCC) REQUIRES EITHER PRIOR TREATMENT WITH A HEDGEHOG PATHWAY INHIBITOR OR INELIGIBILITY FOR HEDGEHOG PATHWAY INHIBITOR TREATMENT.

## LIDOCAINE TOPICALS

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### Products Affected

- Lidocaine PTCH 5%
- Lidocaine/prilocaine CREA

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

# LIVTENCITY

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## Products Affected

- Livtencity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF POST-TRANSPLANT CMV INFECTION/DISEASE REQUIRES A TRIAL OF ONE OF THE FOLLOWING TREATMENTS: GANCICLOVIR, VALGANCICLOVIR, CIDOFOVIR, OR FOSCARNET.



# LONSURF

## Products Affected

- Lonsurf

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	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METATSTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY. COVERAGE FOR THE METASTATIC GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA REQUIRES A TRIAL OF AT LEAST TWO PRIOR LINES OF CHEMOTHERAPY THAT INCLUDES FLUOROPYRIMIDINE, PLATINUM BASED, TAXANE OR IRINOTECAN-BASED CHEMOTHERAPY OR IF APPROPRIATE, AN HER2/NEU-TARGETED THERAPY.

# LORBRENA

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## Products Affected

- Lorbrena

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

# LUMAKRAS

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## Products Affected

- Lumakras

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

# LYBALVI

## Products Affected

- Lybalvi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, FLUPHENAZINE, HALOPERIDOL, LOXAPINE, LURASIDONE, MOLINDONE, PALIPERIDONE, PIMOZIDE, QUETIAPINE, RISPERIDONE, THIORIDAZINE, THIOTHIXENE, TRIFLUOPERAZINE, ZIPRASIDONE. COVERAGE FOR PATIENTS 65 YEARS OF AGE OR OLDER ALSO REQUIRES ALL OF THE FOLLOWING: 1) PRESCRIBER CONSIDERATION OF THERAPY MODIFICATION WHEN USING ANTICHOLINERGIC DRUGS IN COMBINATION, 2) PRESCRIBER ACKNOWLEDGEMENT OF SAFETY RISKS (E.G., CONFUSION, DRY MOUTH, BLURRY VISION, CONSTIPATION, URINARY RETENTION, INCREASED RISK OF DEMENTIA), 3) PRESCRIBER AND PATIENT HAVE DISCUSSED THE ABOVE RISKS.

## **LYNPARZA**

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### **Products Affected**

- Lynparza TABS

Prior Authorization Criteria

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	<p>COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm, HER2-NEGATIVE METASTATIC BREAST CANCER REQUIRE PRIOR CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER REQUIRES PREVIOUS ENDOCRINE THERAPY OR CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm METASTATIC PANCREATIC ADENOCARCINOMA REQUIRES A TRIAL OF WHOSE DISEASE HAS NOT PROGRESSED ON AT</p>

Formulary ID: 25351, Version: 8, Effective Date: 01/01/2025

Last Updated: 09/18/2024

Prior Authorization Criteria

	<p>LEAST 16 WEEKS OF FIRST-LINE PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC HOMOLOGUS RECOMBINATION REPAIR (HRR) GENE-MUTATED CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES A TRIAL OF ENZALUTAMIDE OR ABIRATERONE. COVERAGE FOR TREATMENT OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES COMBINATION USE WITH ABIRATERONE AND PREDNISONE OR PREDNISOLONE.</p>
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## LYTGOBI

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### Products Affected

- Lytgobi

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



# MARGENZA

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## Products Affected

- Margenza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES PRIOR TREATMENT WITH TWO OR MORE ANTI-HER2 REGIMENS, AT LEAST ONE OF WHICH WAS FOR METASTATIC DISEASE.

# MEKINIST

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## Products Affected

- Mekinist TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## MEKINIST LIQUID FORMULATION

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### Products Affected

- Mekinist SOLR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

# MEKTOVI

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## Products Affected

- Mektovi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA REQUIRES COMBINATION USE WITH ENCORAFENIB. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH ENCORAFENIB.

# MEMANTINE

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## Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN  
2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	PRIOR AUTHORIZATION APPLIES ONLY TO PATIENTS LESS THAN 30 YEARS OF AGE.

# MIGLUSTAT

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## Products Affected

- Miglustat
- Yargesa

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

# MONJUVI

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## Products Affected

- Monjuvi

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

## MOTPOLY XR

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### Products Affected

- Motpoly Xr

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



# MOVANTIK

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## Products Affected

- Movantik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 1 YEAR
<b>Other Criteria</b>	REQUIRES A DIAGNOSIS OF OPIOID INDUCED CHRONIC CONSTIPATION IN MEMBERS WITH CHRONIC, NON-CANCER PAIN. A MEMBER MUST BE STABLE ON OPIOID THERAPY FOR A MINIMUM OF 2 WEEKS.

## NARCOLEPSY AGENTS

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### Products Affected

- Armodafinil
- Modafinil TABS

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

## NARCOTIC ANALGESICS

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### Products Affected

- Fentanyl Citrate Oral Transmucosal

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

# NAYZILAM

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## Products Affected

- Nayzilam

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

# NERLYNX

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## Products Affected

- Nerlynx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ADVANCED OR METASTATIC HER2-POSITIVE BREAST CANCER IN COMBINATION WITH CAPECITABINE REQUIRES TREATMENT WITH TWO OR MORE PRIOR ANTI-HER2 BASED REGIMENS.

# NEXAVAR

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## Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, DIFFERENTIATED THYROID CARCINOMA (DTC) REQUIRES TRIAL AND FAILURE OF RADIOACTIVE IODINE TREATMENT.

# NINLARO

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## Products Affected

- Ninlaro

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF PATIENTS WITH MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST ONE PRIOR THERAPY AND USE IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE.

## NORTHERA

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### Products Affected

- Droxidopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF MIDODRINE AND FLUDROCORTISONE.



# NUBEQA

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## Products Affected

- Nubeqa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (mHSPC) REQUIRES USE IN COMBINATION WITH DOCETAXEL.

## NUCALA

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### **Products Affected**

- Nucala

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	EGPA: COVERAGE REQUIRES TWO OF THE FOLLOWING CRITERIA THAT ARE TYPICAL OF EGPA: 1) HISTOPATHOLOGICAL EVIDENCE OF EOSINOPHILIC VASCULITIS, PERIVASCULAR EOSINOPHILIC INFILTRATION, OR EOSINOPHIL-RICH GRANULOMATOUS INFLAMMATION, 2) NEUROPATHY, 3) PULMONARY INFILTRATES, 4) ALLERGIC RHINITIS AND NASAL POLYPS, 5) CARDIOMYOPATHY, 6) GLOMERULONEPHRITIS, 7) ALVEOLAR HEMORRHAGE, 8) PALPABLE PURPURA, 9) ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA) POSITIVITY.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR EA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR EA ALSO REQUIRES CONCURRENT STANDARD OF CARE REGIMEN. COVERAGE FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA AND

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Last Updated: 09/18/2024

Prior Authorization Criteria

	<p>HISTORY OR PRESENCE OF ASTHMA. COVERAGE FOR HYPEREOSINOPHILIC SYNDROME (HES) REQUIRES DIAGNOSIS OF HES AND EOSINOPHIL COUNT OF AT LEAST 1000 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR HES ALSO REQUIRES BOTH OF THE FOLLOWING: 1) TWO HES FLARES WITHIN THE PAST 12 MONTHS (WORSENING SYMPTOMS OR EOSINOPHIL COUNTS REQUIRING ESCALATION IN THERAPY) AND STABILITY ON HES THERAPY (SUCH AS ORAL CORTICOSTEROIDS, IMMUNOSUPPRESSIVE, OR CYTOTOXIC THERAPY). COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP, CONCURRENT STANDARD OF CARE REGIMEN, AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>
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# NUEDEXTA

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## Products Affected

- Nuedexta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE REQUIRES THE PRESENCE OF AN UNDERLYING NEUROLOGICAL CONDITION CAUSING SYMPTOMS OF PBA (EX. MULTIPLE SCLEROSIS, AMYOTROPHIC LATERAL SCLEROSIS, PARKINSON’S DISEASE, STROKE, TRAUMATIC BRAIN INJURY)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## NUPLAZID

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### Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

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

## OCTREOTIDE ACETATE

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ACROMEGALY REQUIRES TRIAL OF BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES.

## ODOMZO

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### Products Affected

- Odomzo

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



## OFEV

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### Products Affected

- Ofev

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

## OGSIVEO

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### Products Affected

- Ogsiveo

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

## OJEMDA

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### Products Affected

- Ojemda TABS

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

## OJEMDA LIQUID FORMULATION

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### Products Affected

- Ojemda SUSR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.

## OJJAARA

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### Products Affected

- Ojjaara

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

# ONUREG

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## Products Affected

- Onureg

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE IS PROVIDED FOR ADULT PATIENTS WITH ACUTE MYELOID LEUKEMIA WHO ACHIEVED FIRST COMPLETE REMISSION (CR) OR COMPLETE REMISSION WITH INCOMPLETE BLOOD COUNT RECOVERY (CRi) FOLLOWING INTENSIVE INDUCTION CHEMOTHERAPY AND ARE NOT ABLE TO COMPLETE INTENSIVE CURATIVE THERAPY.

## OPFOLDA

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### Products Affected

- Opfolda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES CONFIRMATION OF DIAGNOSIS BY SERUM ASSAY SHOWING A DECREASE OF ACID ALPHA-GLUCOSIDASE ACTIVITY FOLLOWED BY GENETIC TESTING SHOWING A MUTATION IN THE GAA GENE.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE PRESENCE OF SYMPTOMATIC MANIFESTATIONS OF THE DISEASE INCLUDING, BUT NOT LIMITED TO: PROGRESSIVE MUSCLE WEAKNESS, RESPIRATORY FAILURE, FREQUENT UPPER AIRWAY INFECTIONS, ORTHOPNEA, SLEEP APNEA, AND/OR MORNING HEADACHES (MUST NOT BE PRESENT WITH ONLY CARDIAC HYPERTROPHY). COVERAGE REQUIRES NO IMPROVEMENT ON CURRENT ENZYME REPLACEMENT THERAPY (ERT).

## ORENCIA

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### **Products Affected**

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



Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS)
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR THE PROPHYLAXIS OF ACUTE GRAFT VERSUS HOST DISEASE (AGVHD) IN ADULTS AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER REQUIRES COMBINATION USE WITH A CALCINEURIN INHIBITOR AND METHOTREXATE. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING ABATACEPT IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS).

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Last Updated: 09/18/2024

# ORFADIN

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## Products Affected

- Nitisinone

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

# ORGOVYX

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## Products Affected

- Orgovyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO FIRMAGON.

# ORKAMBI

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## Products Affected

- Orkambi

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

## ORSERDU

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### Products Affected

- Orserdu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ER-POSITIVE, HER2-NEGATIVE, ESR1-MUTATED ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR TREATMENT WITH AT LEAST ONE LINE OF ENDOCRINE THERAPY

# OTEZLA

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## Products Affected

- Otezla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF PLAQUE PSORIASIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# PADCEV

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## Products Affected

- Padcev

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER REQUIRES PRIOR TREATMENT WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND PLATINIUM-CONTAINING CHEMOTHERAPY OR ARE INELIGIBLE FOR CISPLATING-CONTAINING CHEMOTHERAPY AND HAVE PREVIOUSLY RECEIVED ONE OR MORE PRIOR LINES OF THERAPY.

## PANRETIN

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### Products Affected

- Panretin

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



## PEMAZYRE

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### Products Affected

- Pemazyre

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

# PHENOBARBITAL

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## Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG

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

## PIQRAY

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### Products Affected

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

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TREATMENT OF ADULTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, PIK3CA-MUTATED, ADVANCED OR METASTATIC BREAST CANCER REQUIRES PROGRESSION ON OR AFTER AN ENDOCRINE-BASED REGIMEN AND COMBINATION THERAPY WITH FULVESTRANT.

# POLIVY

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## Products Affected

- Polivy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED (NOS) REQUIRES TRIAL OF AT LEAST TWO PRIOR THERAPIES.

# POMALYST

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## Products Affected

- Pomalyst

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR MULTIPLE MYELOMA REQUIRES 1) AT LEAST TWO PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR, IN PATIENTS WHO HAVE DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF THE LAST THERAPY, AND 2) COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR AIDS-RELATED KAPOSI SARCOMA (KS) REQUIRES TRIAL AND FAILURE OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART).

## **POSACONAZOLE DR**

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### **Products Affected**

- Posaconazole Dr

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 MONTHS
<b>Other Criteria</b>	<p>COVERAGE FOR PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS (IFI): 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 [E.G., ACUTE MYELOID LEUKEMIA (AML), MYELOYDYSPLASTIC SYNDROME (MDS)], OR 2) PATIENT HAS A PRIOR FUNGAL INFECTION REQUIRING SECONDARY PROPHYLAXIS. COVERAGE FOR PROPHYLAXIS ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE.</p> <p>COVERAGE FOR TREATMENT OF IFI: USED AS TREATMENT OF INVASIVE FUNGAL INFECTIONS CAUSED BY ASPERGILLUS AND CANDIDA. COVERAGE FOR TREATMENT ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE.</p>

## PREVYMIS

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### Products Affected

- Prevymis TABS

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CYTOMEGALOVIRUS (CMV) PROPHYLAXIS, IN CMV-SEROPOSITIVE RECIPIENT [R+] OF AN ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT), OR, IN KIDNEY TRANSPLANT RECIPIENTS AT HIGH RISK [DONOR IS CMV SEROPOSITIVE/RECIPIENT IS CMV SERONEGATIVE: D+/R- ]



# PROLIA

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## Products Affected

- Prolia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR HYPOCALCEMIA.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 YEARS
<b>Other Criteria</b>	PROLIA IS SUBJECT TO PART B VERSUS PART D REVIEW. COVERAGE REQUIRES TRIAL OF AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH BOTH ORAL AND INTRAVENOUS BISPHOSPHONATES.

## PROMACTA

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### Products Affected

- Promacta TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR A DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA (ITP) REQUIRES BASELINE PLATELET COUNT OF less than 30,000 MCL AND SYMPTOMS OF ACTIVE BLEEDING. COVERAGE FOR A DIAGNOSIS OF THROMBOCYTOPENIA WITH CHRONIC HEPATITIS C REQUIRES BASELINE PLATELET COUNT less than 75,000 MCL. COVERAGE FOR A DIAGNOSIS OF SEVERE APLASTIC ANEMIA REQUIRES BASELINE PLATELET COUNT OF less than 30,000 MCL
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR ITP REQUIRES TRIAL OF CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY

## **PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS**

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### **Products Affected**

- Ambrisentan
- Sildenafil Citrate TABS 20MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR SILDENAFIL IN SITUATIONS WHERE PATIENTS ARE RECEIVING NITRATE THERAPY.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# QINLOCK

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## Products Affected

- Qinlock

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	One Year
Other Criteria	COVERAGE FOR ADULT PATIENTS WITH ADVANCED GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PRIOR THERAPY WITH 3 OR MORE KINASE INHIBITORS, INCLUDING IMATINIB.

# QUININE

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## Products Affected

- Quinine Sulfate CAPS 324MG

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

# QULIPTA

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## Products Affected

- Qulipta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE).

## RECORLEV

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### Products Affected

- Recorlev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF KETOCONAZOLE, MITOTANE, OR CABERGOLINE.

## REPATHA

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### Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



## RETEVMO

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### Products Affected

- Retevmo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## REVLIMID

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### Products Affected

- Lenalidomide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR MULTIPLE MYELOMA REQUIRES COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR MANTLE CELL LYMPHOMA REQUIRES DISEASE RELAPSE OR PROGRESSION AFTER TWO PRIOR THERAPIES, ONE OF WHICH INCLUDES BORTEZOMIB. COVERAGE FOR PREVIOUS TREATED FOLLICULAR LYMPHOMA OR PREVIOUSLY TREATED MARGINAL ZONE LYMPHOMA REQUIRES COMBINATION USE WITH A RITUXIMAB PRODUCT.

## REZLIDHIA

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### Products Affected

- Rezlidhia

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

## REZUROCK

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### Products Affected

- Rezurock

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ADULT AND PEDIATRIC PATIENTS 12 YEARS AND OLDER WITH CHRONIC GRAFT-VERSUS-HOST DISEASE (CHRONIC GVHD) REQUIRES TRIAL AND FAILURE OF AT LEAST TWO PRIOR LINES OF SYSTEMIC THERAPY.

# RINVOQ

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## Products Affected

- Rinvoq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## RINVOQ LIQUID FORMULATION

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### Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING UPADACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).

# RIVFLOZA

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## Products Affected

- Rivfloza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS, 1) PATIENT HAS A HISTORY OF KIDNEY OR LIVER TRANSPLANT, 2) COMBINATION USE WITH OXLUMO.
<b>Required Medical Information</b>	DIAGNOSIS OF PRIMARY HYPEROXALURIA TYPE 1 (PH1) CONFIRMED BY GENETIC TESTING OF THE AGXT MUTATION.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ROZLYTREK

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### Products Affected

- Rozlytrek

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



## RUBRACA

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### Products Affected

- Rubraca

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE IS PROVIDED FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN COMPLETE OR PARTIAL RESPONSE TO PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES PREVIOUS THERAPY WITH ANDROGEN RECEPTOR-DIRECTED THERAPY AND A TAXANE-BASED CHEMOTHERAPY.

# RYBREVANT

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## Products Affected

- Rybrevant

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATIONS REQUIRES DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY.

# RYDAPT

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## Products Affected

- Rydapt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 MUTATION-POSITIVE REQUIRES COMBINATION THERAPY WITH STANDARD CYTARABINE AND DAUNORUBICIN INDUCTION AND CYTARABINE CONSOLIDATION.

# RYLAZE

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## Products Affected

- Rylaze

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

## SAPROPTERIN HYDROCHLORIDE

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### Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	INITIAL - 2 MONTHS AUTH WILL BE EXTENDED FOR 1 YEAR IF DOCUMENTED RESPONSE AFTER INITIAL THERAPY
<b>Other Criteria</b>	RENEWAL CRITERIA: PATIENT MUST SHOW IMPROVEMENT AFTER INITIAL THERAPY OF 2 MONTHS.

# SARCLISA

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## Products Affected

- Sarclisa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST 2 PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR. COVERAGE FOR RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TREATMENT WITH 1 TO 3 PRIOR LINES OF THERAPY.

# SAVELLA

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**Products Affected**

- Savella
- Savella Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF FIBROMYALGIA REQUIRES A TRIAL OF GABAPENTIN.

## SCSEMBLIX

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### Products Affected

- Scemblix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



## SECUADO

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### Products Affected

- Secuado

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF ASENAPINE TABLET (SUBLINGUAL), OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL OR ORALLY DISINTEGRATING TABLET (ODT) FORMULATIONS

## SIGNIFOR

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### Products Affected

- Signifor

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

# SIRTURO

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## Products Affected

- Sirturo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	MUST BE USED IN COMBINATION WITH AT LEAST 3 OTHER AGENTS.

# SKYRIZI

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## Products Affected

- Skyrizi INJ 150MG/ML
- Skyrizi Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSORIATIC ARTHRITIS. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

## SKYRIZI 360 MG

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### Products Affected

- Skyrizi INJ 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX/TREXALL). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# SOHONOS

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**Products Affected**

- Sohonos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR A DIAGNOSIS OF FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) REQUIRES GENETIC TESTING CONFIRMATION SHOWING AN ACVR1 MUTATION.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## SOMATULINE DEPOT

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### Products Affected

- Lanreotide Acetate
- Somatuline Depot

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

## SOMAVERT

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### Products Affected

- Somavert

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



# SPRITAM

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## Products Affected

- Spritam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# SPRYCEL

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## Products Affected

- Dasatinib
- Sprycel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB. COVERAGE FOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) REQUIRES ONE OF THE FOLLOWING: 1) SPRYCEL TO BE USED IN COMBINATION WITH CHEMOTHERAPY IN NEWLY DIAGNOSED ALL OR 2) RESISTANCE OR INTOLERANCE TO PRIOR THERAPY.

## STELARA

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### Products Affected

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

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	COVERAGE OF 90MG/ML STRENGTH FOR A DIAGNOSIS OF PSA OR PLAQUE PSORIASIS REQUIRES PATIENT WEIGHT GREATER THAN 100KG (220LBS).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE (PURINETHOL), AZATHIOPRINE (IMURAN), A CORTICOSTEROID (EG, PREDNISON, METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX, TREXALL). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPURINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE (AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN), CORTICOSTEROIDS (E.G., PREDNISON, METHYLPREDNISOLONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

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Last Updated: 09/18/2024

# STIVARGA

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## Products Affected

- Stivarga

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR COLORECTAL CANCER (CRC) REQUIRES PREVIOUS TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY, AN ANTI-VEGF THERAPY, AND, IF RAS WILD-TYPE, AN ANTI-EGFR THERAPY. COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PREVIOUS TREATMENT WITH IMATINIB MESYLATE AND SUNITINIB MALATE. COVERAGE FOR HEPATOCELLULAR CARCINOMA (HCC) REQUIRES PREVIOUS TREATMENT WITH SORAFENIB.

# SUNOSI

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## Products Affected

- Sunosi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF ARMODAFINIL

# SUTENT

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**Products Affected**

- Sunitinib Malate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by an oncologist
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES DISEASE PROGRESSION ON OR INTOLERANCE TO IMATINIB MESYLATE

## SYMPAZAN

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### Products Affected

- Clobazam
- Sympazan

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



## TABLOID

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### Products Affected

- Tabloid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by an oncologist or hematologist
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# TABRECTA

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## Products Affected

- Tabrecta

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

# TAFINLAR

## Products Affected

- Tafinlar CAPS

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG).</p>

## TAFINLAR LIQUID FORMULATION

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### Products Affected

- Tafinlar TBSO

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	1 YEAR
Other Criteria	<p>COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG). COVERAGE FOR ALL CONDITIONS REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW CAPSULE FORMULATION.</p>

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# TAGRISO

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## Products Affected

- Tagrisso

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETION- OR EXON 21 L858R MUTATION- POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES TAGRISO TO BE USED 1) AS ADJUVANT THERAPY AFTER TUMOR RESECTION, 2) AS FIRST-LINE TREATMENT IN METASTATIC DISEASE, OR 3) AS FIRST-LINE TREATMENT IN LOCALLY ADVANCED OR METASTATIC DISEASE IN COMBINATION WITH PEMETREXED AND PLANTIUM-BASED CHEMOTHERAPY. COVERAGE FOR EGFR T790M MUTATION- POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES DISEASE PROGRESSION ON OR AFTER EGFR TYROSINE KINASE INHIBITOR (TKI) THERAPY.

# TALZENNA

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## Products Affected

- Talzenna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES TALZENNA TO BE USED IN COMBINATION WITH ENZALUTAMIDE

# TARCEVA

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## Products Affected

- Erlotinib Hydrochloride TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

# TARGRETIN

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## Products Affected

- Bexarotene

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



# TASIGNA

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## Products Affected

- Tassigna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB.

# TAVNEOS

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## Products Affected

- Tavneos

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

# TAZAROTENE

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## Products Affected

- Tazarotene CREA 0.1%
- Tazarotene GEL 0.05%

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

# TAZVERIK

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## Products Affected

- Tazverik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR EZH2 MUTATION-POSITIVE FOLLICULAR LYMPHOMA REQUIRES PRIOR TREATMENT WITH AT LEAST TWO SYSTEMIC THERAPIES

# TECFIDERA

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## Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack  
CDPK 0

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

# TEPMETKO

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## Products Affected

- Tepmetko

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

# TESTOSTERONE

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## Products Affected

- Testosterone GEL 25MG/2.5GM

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

# TETRABENAZINE

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## Products Affected

- Tetrabenazine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS, 1) HEPATIC FUNCTION IMPAIRMENT 2) ACTIVELY SUICIDAL OR WHO HAVE UNTREATED OR INADEQUATELY TREATED DEPRESSION, 3) TAKING MONOAMINE OXIDASE INHIBITORS OR RESERPINE.
<b>Required Medical Information</b>	DOCUMENTATION OF THE CYP2D6 GENOTYPE OF THE PATIENT WILL BE REQUIRED FOR DOSES ABOVE 50MG PER DAY.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# THALOMID

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## Products Affected

- Thalomid

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR MULTIPLE MYELOMA (MM) REQUIRES THALOMID TO BE USED IN COMBINATION WITH DEXAMETHASONE. COVERAGE FOR ACUTE TREATMENT OF ERYTHEMA NODOSUM LEPROSUM (ENL) WITH PRESENCE OF MODERATE TO SEVERE NEURITIS REQUIRES THALOMID TO BE PART OF A COMBINATION THERAPY.

# TIBSOVO

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## Products Affected

- Tibsovo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR CHOLANGIOCARCINOMA REQUIRES PREVIOUS TREATMENT

# TIVDAK

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## Products Affected

- Tivdak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RECURRENT OR METASTATIC CERVICAL CANCER REQUIRES DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY.

# TOBI PODHALER

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## Products Affected

- Tobii Podhaler

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF GENERIC TOBRAMYCIN INHALATION NEBULIZATION SOLUTION.

## TOPICAL TRETINOIN

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### Products Affected

- Tretinoin CREA
- Tretinoin GEL 0.01%, 0.025%

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

# TRELSTAR

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## Products Affected

- Trelstar Mixject INJ 11.25MG, 3.75MG

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

## TRIENTINE HCL

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### Products Affected

- Trientine Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR WILSON'S DISEASE WHO ARE INTOLERANT TO PENCILLAMINE.

# TRIKAFTA

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## Products Affected

- Trikafta

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



# TRODELVY

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## Products Affected

- Trodelvy

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC TRIPLE-NEGATIVE BREAST CANCER (MTNBC) REQUIRES PRIOR USE OF TWO OR MORE SYSTEMIC THERAPIES, WITH AT LEAST ONE OF THEM FOR METASTATIC DISEASE. COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC HORMONE RECEPTOR POSITIVE (HR+), HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 NEGATIVE (HER2-) (IHC 0, IHC 1+ OR IHC 2+/ISH-) BREAST CANCER REQUIRES PRIOR USE OF ENDOCRINE-BASED THERAPY AND AT LEAST TWO ADDITIONAL SYSTEMIC THERAPIES IN THE METASTATIC SETTING. COVERAGE FOR LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER (MUC) REQUIRES PRIOR USE OF PLATINUM-CONTAINING CHEMOTHERAPY AND EITHER PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH LIGAND 1 (PD-L1) INHIBITOR.

# TRUQAP

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## Products Affected

- Truqap

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER WITH ONE OR MORE PIK3CA/AKT1/PTEN-ALTERATIONS REQUIRES PROGRESSION ON AT LEAST ONE ENDOCRINE BASED REGIMEN OR RECURRENCE ON OR WITHIN 12 MONTHS OF COMPLETING ADJUVANT THERAPY AND COMBINATION USE WITH FULVESTRANT

# TUKYSA

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## Products Affected

- Tukysa

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ADVANCED UNRESECTABLE OR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES A TRIAL OF ONE OR MORE PRIOR ANTI-HER2-BASED REGIMENS AND COMBINATION THERAPY WITH TRASTUZUMAB AND CAPECITABINE. COVERAGE FOR RAS WILD-TYPE HER2-POSITIVE UNRESECTABLE OR METASTATIC COLORECTAL CANCER REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY AND COMBINATION THERAPY WITH TRASTUZUMAB

# TURALIO

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## Products Affected

- Turalio CAPS 125MG

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

# TYKERB

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## Products Affected

- Lapatinib Ditosylate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ADVANCED OR METASTATIC BREAST CANCER WHOSE TUMORS OVEREXPRESS HER2 RECEPTOR REQUIRES A TRIAL OF PRIOR THERAPY INCLUDING AN ANTHRACYCLINE, A TAXANE, AND TRASTUZUMAB AND COMBINATION USE WITH CAPECITABINE. COVERAGE FOR HORMONE RECEPTOR-POSITIVE METASTATIC BREAST CANCER THAT OVEREXPRESS HER2 RECEPTORS AND COMBINATION USE WITH LETROZOLE.

# TYMLOS

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## Products Affected

- Tymlos

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 YEARS
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF BOTH 1) PROLIA AND 2) EITHER AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH ALL OF THE FOLLOWING: PROLIA, AN ORAL BISPHOSPHONATE, AND AN INTRAVENOUS BISPHOSPHONATE.

# UBRELVY

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## Products Affected

- Ubrelvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN.

# VALCHLOR

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## Products Affected

- Valchlor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR TOPICAL TREATMENT OF STAGE 1A AND 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA REQUIRES PRIOR SKIN-DIRECTED THERAPY.



# VALTOCO

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## Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

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

## VANFLYTA

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### Products Affected

- Vanflyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 INTERNAL TANDEM DUPLICATION (ITD) POSITIVE REQUIRES USE IN COMBINATION WITH STANDARD CYTARABINE AND ANTHRACYCLINE INDUCTION AND CYTARABINE CONSOLIDATION.

## VENCLEXTA

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### Products Affected

- Venclexta
- Venclexta Starting Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

# VEOZAH

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**Products Affected**

- Veozah

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR MODERATE-TO-SEVERE VASOMOTOR SYMPTOMS (VMS) DUE TO MENOPAUSE REQUIRES A TRIAL, FAILURE, CONTRAINDICATION OR INTOLERANCE TO ONE PREFERRED OR GENERIC MEDICATION FOR THE TREATMENT OF VMS.

# VERQUVO

## Products Affected

- Verquvo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE REQUIRES A DIAGNOSIS OF CHRONIC HEART FAILURE NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV AND LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF LESS THAN 45%. COVERAGE ALSO REQUIRES ONE OF THE FOLLOWING: 1. PREVIOUS HOSPITALIZATION FOR HEART FAILURE WITHIN PRIOR 6 MONTHS OR 2. OUTPATIENT INTRAVENOUS (IV) DIURETIC TREATMENT FOR HEART FAILURE WITHIN PRIOR 3 MONTHS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	MUST BE TAKEN IN COMBINATION WITH AT LEAST TWO OF THE FOLLOWING UNLESS CONTRAINDICATED OR NOT TOLERATED: 1. METOPROLOL SUCCINATE, CARVEDILOL, OR BISOPROLOL 2. AN ACE-INHIBITOR (ACE, SUCH AS LISINOPRIL), ANGIOTENSIN RECEPTOR BLOCKER (ARB, SUCH AS LOSARTAN), OR ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR (ARNI, SUCH AS SACUBITRIL/VALSARTAN) 3. A SODIUM GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR APPROVED FOR HEART FAILURE 4. A MINERALOCORTICOID RECEPTOR ANTAGONIST

## VERZENIO

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### Products Affected

- Verzenio

Prior Authorization Criteria

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	<p>COVERAGE FOR THE ADJUVANT TREATMENT OF ADULT PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, NODE POSITIVE, EARLY BREAST CANCER AT HIGH RISK OF RECUURENCE REQUIRES COMBINATION USE WITH TAMOXIFEN OR AN AROMATASE INHIBITOR. COVERAGE FOR HR-POSITIVE, HER2-NETAGIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION THERAPY WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE BASED THERAPY. COVERAGE FOR HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY REQUIRES COMBINATION USE WITH FULVESTRANT. COVERAGE AS MONOTHERAPY FOR THE TREATMENBT OF ADULT PATIENTS WITH HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR ENDOCRINE AND CHEMOTHERAPY IN THE METASTATIC SETTING.</p>

## VIGABATRIN

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### Products Affected

- Vigabatrin

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



## VITRAKVI

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### Products Affected

- Vitrakvi

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

## VIZIMPRO

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### Products Affected

- Vizimpro

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

## VONJO

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### Products Affected

- Vonjo

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

# VORICONAZOLE

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**Products Affected**

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

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

# VOSEVI

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## Products Affected

- Vosevi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

## VOTRIENT

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### Products Affected

- Pazopanib Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by an oncologist
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ADVANCED TISSUE SARCOMA (STS) REQUIRES PREVIOUS TREATMENT WITH CHEMOTHERAPY.

# VOWST

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## Products Affected

- Vowst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	60 DAYS
<b>Other Criteria</b>	N/A

# VOYDEYA

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## Products Affected

- Voydeya

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR THE TREATMENT OF EXTRAVASCULAR HEMOLYSIS (EVH) WITH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) REQUIRES THAT THE PATIENT MUST HAVE CLINICALLY SIGNIFICANT EVH DUE TO PNH WITH THE FOLLOWING: HEMOGLOBIN (HGB) LESS THAN OR EQUAL TO 9.5 G/DL AND ABSOLUTE RETICULOCYTE COUNT GREATER THAN OR EQUAL TO $120 \times 10^9/L$ .
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF EVH WITH PNH REQUIRES COMBINATION USE WITH SOLIRIS OR ULTOMIRIS ONLY.



## WELIREG

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### Products Affected

- Welireg

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRES PRIOR THERAPY WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND A VASCULAR ENDOTHELIAL GROWTH FACTOR TYROSINE KINASE INHIBITOR (VEGF-TKI).

## XALKORI

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### Products Affected

- Xalkori

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

# XATMEP

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## Products Affected

- Xatmep

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): DIAGNOSIS OF ACUTE LYMPHOBLASTIC LEUKEMIA (ALL). POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) (INITIAL): DIAGNOSIS OF ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. TRIAL AND FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE NONSTEROIDAL ANTIINFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN).
<b>Age Restrictions</b>	ALL: PATIENT IS 18 YEARS OF AGE OR YOUNGER. PJIA (INITIAL): PATIENT IS 18 YEARS OF AGE OR YOUNGER.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **Xcopri**

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### **Products Affected**

- Xcopri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# XDEMVY

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## Products Affected

- Xdemvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR DEMODEX BLEPHARITIS REQUIRES CONFIRMATION OF DIAGNOSIS OF DEMODEX BLEPHARITIS VIA THE PRESENCE OF COLLARETTES UPON EXAMINATION WITH A SLIT LAMP.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## **XELJANZ**

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### **Products Affected**

- Xeljanz
- Xeljanz Xr

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE

Formulary ID: 25351, Version: 8, Effective Date: 01/01/2025

Last Updated: 09/18/2024

Prior Authorization Criteria

	<p>(AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN), CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE). FOR ALL INDICATIONS: COVERAGE ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITOR (E.G., ENBREL, HUMIRA) OR DOCUMENTATION DEMONSTRATING THAT A TRIAL MAY BE INAPPROPRIATE. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING TOFACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).</p>
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## XERMELO

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### Products Affected

- Xermelo

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF CARCINOID SYNDROME DIARRHEA REQUIRES A TRIAL OF SOMATOSTATIN ANALOG (SSA) THERAPY (E.G., OCTREOTIDE, SOMATULINE).

## XGEVA

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### Products Affected

- Xgeva

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

# XIFAXAN

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## Products Affected

- Xifaxan TABS 550MG

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	1 YEAR
Other Criteria	COVERAGE FOR A DIAGNOSIS OF HEPATIC ENCEPHALOPATHY REQUIRES A TRIAL OF LACTULOSE. COVERAGE FOR IRRITABLE BOWEL SYNDROME WITH DIARRHEA REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING: LOPERAMIDE, DICYCLOMINE, OR DIPHENOXYLATE/ATROPINE. COVERAGE FOR RECURRENT CLOSTRIDIUM DIFFICILE DIARRHEA (C. DIFF) REQUIRES TRIAL OF VANCOMYCIN. COVERAGE FOR SMALL INTESTINAL BACTERIAL OVER-GROWTH (SIBO) IS NOT PROVIDED.

## **XOLAIR**

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### **Products Affected**

- Xolair

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	ALLERGIC ASTHMA: IMMUNOGLOBULIN E (IGE) LEVEL GREATER THAN 30 AND LESS THAN 700 UNITS PER MILLILITER (IU/ML) FOR 12 YEARS AND OLDER, GREATER THAN 30 AND LESS THAN 1300 IU/ML FOR 6 YEARS THROUGH 12 YEARS CRSWNP: IMMUNOGLOBULIN E (IGE) LEVEL BETWEEN 30 AND 1500 IU/ML AT INITIATION OF TREATMENT
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR UNCONTROLLED MODERATE TO SEVERE ALLERGIC ASTHMA REQUIRES DIAGNOSIS OF THIS CONDITION WITH A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN. COVERAGE FOR THIS CONDITION ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR CHRONIC IDIOPATHIC URTICARIA (CIU) REQUIRES A DIAGNOSIS OF CIU AND A TRIAL OF AT LEAST ONE SECOND GENERATION ANTIHISTAMINE AND ONE OF THE FOLLOWING: ANOTHER SECOND-GENERATION ANTIHISTAMINE, H2 ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, FIRST GENERATION ANTIHISTAMINE, HYDROXYZINE, OR DOXEPIN. COVERAGE

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Last Updated: 09/18/2024

Prior Authorization Criteria

	FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP, CONCURRENT STANDARD OF CARE REGIMEN, AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
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## XOSPATA

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### Products Affected

- Xospata

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

## XPHOZAH

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### Products Affected

- Xphozah

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



# XPOVIO

## 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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH MULTIPLE MYELOMA REQUIRES FAILURE OF ONE PRIOR THERAPY. COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TRIAL OF AT LEAST FOUR PRIOR THERAPIES (REFRACTORY TO AT LEAST TWO PROTEASOME INHIBITORS, AT LEAST TWO IMMUNOMODULATORY AGENTS, AND AN ANTI-CD38 MONOCLONAL ANTIBODY). COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) REQUIRES TRIAL OF AT LEAST 2 LINES OF SYSTEMIC THERAPY.

# XTANDI

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## Products Affected

- Xtandi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CASTRATION RESISTANT PROSTATE CANCER (CRPC), METASTATIC CASTRATION RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION SENSITIVE PROSTATE CANCER (MCSPC), AND HIGH-RISK NONMETASTATIC PROSTATE CANCER REQUIRE TRIAL OF ABIRATERONE, USING THE 250MG TABLET STRENGTH

## XYREM

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### Products Affected

- Sodium Oxybate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review

## ZARXIO

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### Products Affected

- Zarxio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR ACUTE MYELOID LEUKEMIA (AML) REQUIRES PRIOR INDUCTION OR CONSOLIDATION CHEMOTHERAPY TREATMENT.

## ZEJULA

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### Products Affected

- Zejula

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE MAINTENANCE TREATMENT OF ADULTS WITH ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER OR FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMPLETE OR PARTIAL RESPONSE TO FIRST-LINE PLATINUM-BASED CHEMOTHERAPY.

## ZELBORAF

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### Products Affected

- Zelboraf

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

## ZEPZELCA

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### Products Affected

- Zepzelca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR METASTATIC SMALL CELL LUNG CANCER (SCLC) REQUIRES DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY.

## ZILBRYSQ

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### Products Affected

- Zilbrysq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	Pending CMS Review
<b>Off-Label Uses</b>	Pending CMS Review
<b>Exclusion Criteria</b>	Pending CMS Review
<b>Required Medical Information</b>	Pending CMS Review
<b>Age Restrictions</b>	Pending CMS Review
<b>Prescriber Restrictions</b>	Pending CMS Review
<b>Coverage Duration</b>	Pending CMS Review
<b>Other Criteria</b>	Pending CMS Review



## ZOLINZA

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### Products Affected

- Zolinza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF CUTANEOUS MANIFESTATIONS IN PATIENTS WITH CUTANEOUS T-CELL LYMPHOMA WHO HAVE PROGRESSIVE, PERSISTENT OR RECURRENT DISEASE REQUIRES TRIAL OF TWO SYSTEMIC THERAPIES

## ZONISADE

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### Products Affected

- Zonisade

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC ZONISAMIDE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES

## ZTALMY

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### Products Affected

- Ztalmy

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

## ZURZUVAE

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### Products Affected

- Zurzuvae

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR POSTPARTUM DEPRESSION (PPD) REQUIRES BOTH OF THE FOLLOWING: 1. A DIAGNOSIS OF PPD WITH AN ONSET OF DEPRESSIVE SYMPTOMS IN THE THIRD TRIMESTER OR WITHIN 4 WEEKS POSTPARTUM AND 2. MEMBER IS CURRENTLY LESS THAN OR EQUAL TO 12 MONTHS POSTPARTUM.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	60 Days
<b>Other Criteria</b>	N/A

## ZYDELIG

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### Products Affected

- Zydelig

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

## ZYKADIA

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### Products Affected

- Zykadia TABS

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

## **PART B VERSUS PART D**

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## Prior Authorization Criteria

### 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
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Astagraf XL
- Azathioprine TABS 100MG, 50MG
- Budesonide SUSP
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepelisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Prehevbrio



## Prior Authorization Criteria

- 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 PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU 300MG/5ML
- 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
- Ventavis

## Prior Authorization Criteria

### **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.

## **ABILIFY ASIMTUFII**

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### **Products Affected**

- Abilify Asimtufii

### **Details**

<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME
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## **ABILIFY MAINTENA**

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### **Products Affected**

- Abilify Maintena

### **Details**

<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.
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## ANTIDEPRESSANTS

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### Products Affected

- Trintellix

### Details

<b>Criteria</b>	REQUIRES TRIAL OF AT LEAST 2 OF THE FOLLOWING GENERIC DRUGS: BUPROPION, CITALOPRAM, DESVENLAFAXINE, DULOXETINE, ESCITALOPRAM, FLUOXETINE, FLUVOXAMINE, MIRTAZAPINE, NEFAZODONE, PHENELZINE, PROTRIPTYLINE, SERTRALINE, TRANYLCYPROMINE, TRAZODONE, TRIMIPRAMINE, VENLAFAXINE, VILAZODONE. COVERAGE DURATION IS LIFETIME.
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## ANTIPSYCHOTIC AGENTS

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### Products Affected

- Caplyta
- Rexulti
- Vraylar
- Zyprexa Relprevv

### Details

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<b>Criteria</b>	Pending CMS Review
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## ARISTADA

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### Products Affected

- Aristada

### Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME
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## ARISTADA INITIO

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### Products Affected

- Aristada Initio

### Details

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<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.
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## BYSTOLIC

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### Products Affected

- Nebivolol Hydrochloride

### Details

<b>Criteria</b>	REQUIRES THAT MEMBER HAS TRIED OR IS INTOLERANT TO AT LEAST 2 OF THE FORMULARY CARDIOSELECTIVE BETA BLOCKERS. COVERAGE DURATION IS LIFETIME.
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# HUMALOG

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## Products Affected

- Humalog Kwikpen INJ 200UNIT/ML

## Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO NOVOLOG 70/30 OR NOVOLOG. COVERAGE DURATION IS LIFETIME.
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## INSULIN DELIVERY SUPPLIES

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### Products Affected

- Alcohol Prep Pads PADS 70%
- Curity Gauze Pads 2"x2" 12 Ply

### Details

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<b>Criteria</b>	COVERAGE REQUIRES A CLAIM FOR AN INSULIN PRODUCT IN THE LAST 180 DAYS. COVERAGE DURATION IS 1 YEAR.
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# INVEGA HAFYERA

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## Products Affected

- Invega Hafyera

## Details

<b>Criteria</b>	REQUIRES TRIAL OF A ONCE-A MONTH PALIPERIDONE PALMITATE EXTENDED-RELEASE INJECTABLE SUSPENSION FOR AT LEAST 4 MONTHS OR AN EVERY-THREE-MONTH PALIPERIDONE PALMITATE EXTENDED -RELEASE INJECTABLE SUSPENSION FOR AT LEAST ONE THREE MONTH CYCLE. COVERAGE DURATION IS LIFETIME.
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# INVEGA SUSTENNA

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## Products Affected

- Invega Sustenna

## Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL PALIPERIONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# INVEGA TRINZA

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## Products Affected

- Invega Trinza

## Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL PALIPERIDONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## PERSERIS

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### Products Affected

- Perseris

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME
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## **RHOPRESSA**

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### **Products Affected**

- Rhopressa

### **Details**

<b>Criteria</b>	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.
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## RISPERDAL CONSTA

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### Products Affected

- Risperidone Er

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## ROCKLATAN

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### Products Affected

- Rocklatan

### Details

<b>Criteria</b>	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.
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## **RYKINDO**

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### **Products Affected**

- Rykindo

### **Details**

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<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# **RYTARY**

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## **Products Affected**

- Rytary

## **Details**

<b>Criteria</b>	COVERAGE REQUIRES TRIAL OF GENERIC ORAL EXTENDED-RELEASE CARBIDOPA & LEVODOPA. COVERAGE DURATION IS 1 YEAR.
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# ULORIC

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## Products Affected

- Febuxostat

## Details

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<b>Criteria</b>	REQUIRES TRIAL OR CONTRAINDICATION OF ALLOPURINOL. COVERAGE DURATION IS LIFETIME.
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# VYTORIN

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## Products Affected

- Ezetimibe/simvastatin

## Details

<b>Criteria</b>	REQUIRES TRIAL WITH SIMVASTATIN AND EZETIMIBE AS INDIVIDUAL AGENTS WHEN USED CONCOMITANTLY. COVERAGE DURATION IS LIFETIME.
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