Sentara® Health Plans

SENTARA COMMUNITY COMPLETE (HMO D-SNP) PRIOR AUTHORIZATION CRITERIA

(01/01/2027 – 01/31/2027)

Certain covered drugs may have additional requirements or limitations regarding coverage. We have made available documentation that outlines our criteria for Prior Authorization requirements.

PLEASE READ: This document contains information about some of the drugs we cover in this plan.

The Prior Authorization Criteria was updated on 10/05/2026

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ABIRATERONE ACETATE

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*
- *abirtega*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ACALABRUTINIB

Products Affected

- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	Initial: Member must have a diagnosis of psoriasis with a trial and failure or contraindication to methotrexate or cyclosporine prior to approval. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADAGRASIB

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Initial: Approve if the member has a diagnosis of locally advanced or metastatic NSCLC and meets both of the following A and B: A) Disease has a KRAS G12C-mutation as determined by an FDA-approved test AND B) Member has been previously treated with at least one systemic regimen (i.e. bevacizumab, cisplatin, carboplatin, docetaxel). Colorectal Cancer (CRC)-Initial: Approve if member has a diagnosis of locally advanced or metastatic CRC and meets all criteria A, B, and C: A) Disease has a KRAS G12C-mutation as determined by an FDA-approved test, B) Member has received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, AND C) Medication will be used in combination with cetuximab.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ADALIMUMAB (HADLIMA)

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH
- HADLIMA(CF)
- HADLIMA(CF) PUSHTOUCH

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ADALIMUMAB (SIMLANDI)

Products Affected

- SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML
- SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AFATINIB

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ALITRETINOIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ALOSETRON

Products Affected

- *alosetron*

PA Criteria	Criteria Details
Exclusion Criteria	History of chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, adhesions, ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, Crohns disease or ulcerative colitis, diverticulitis, severe hepatic impairment
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member is natal female with severe diarrhea-predominant irritable bowel syndrome (severe diarrhea defined as one or more of the following: 1) frequent and severe abdominal pain/discomfort, 2) frequent bowel urgency or fecal incontinence, 3) disability or restriction of daily activities due to IBS) AND meets both A and B: A) member has had chronic IBS symptoms (generally lasting 6 months or longer) AND B) had anatomic or biochemical abnormalities of the gastrointestinal tract excluded. Member must have a trial and failure or contraindication to two conventional therapies used to treat IBS-D prior to approval (i.e. loperamide, antispasmodics). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ALPELISIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Breast Cancer-Initial: Approve if the member has advanced or metastatic disease meets the following criteria (A, B, and C): A) Disease is hormone receptor (HR)-positive, has human epidermal growth factor receptor 2 (HER2)-negative, and PIK3CA-mutated breast cancer as detected by an FDA-approved test, B) Disease has progressed on or after an endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, tamoxifen, toremifene) AND C) Medication will be used in combination with fulvestrant injection.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ALPHA 1 PROTEINASE INHIBITORS

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AMIKACIN LIPOSOME (INHALATION)

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections
Coverage Duration	12 months
Other Criteria	Mycobacterium Avium Complex (MAC)-Initial-Approve if the member has a positive sputum culture for mycobacterium avium complex for which the member has limited or no alternative treatment options. Member must have failed to achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g. macrolide (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin)). Member's culture must have been collected after the 6 month multidrug therapy completion. The Mycobacterium avium complex isolate must be susceptible to the requested medication with a minimum inhibitor concentration (MIC) of less than or equal to 64 microgram/mL AND medication will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Reauthorization: Approve if the requested medication will be used in conjunction with a background multidrug regimen AND i. Member meets ONE of the following criteria (A or B): A)Member has not achieved negative sputum cultures for Mycobacterium avium complex OR B) Member has not achieved 3 consecutive negative monthly sputum cultures by month 6.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AMOXICILLIN/CLARITHROMYCIN/VONOPRAZAN

Products Affected

- VOQUEZNA TRIPLE PAK

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of rilpivirine-containing products, pimozide, lomitapide, lovastatin, simvastatin, ergot alkaloids (ergotamine or dihydroergotamine), or lurasidone. In the setting of renal or hepatic impairment, concomitant use of colchicine. Members with a history of cholestatic jaundice or hepatic dysfunction with the use of clarithromycin
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	14 Days
Other Criteria	Member must have a confirmed diagnosis of Helicobacter pylori (H. pylori) that meets either A or B: A) Member meets a, b, and c: a) has had a trial and failure with optimized bismuth quadruple therapy (e.g., proton pump inhibitor (i.e., omeprazole 20 mg) twice daily, tetracycline 500 mg four times daily, metronidazole 500 mg three to four times daily, and bismuth subsalicylate 300 mg four times daily all taken for a duration of 14 days) AND b) member had a positive urea breath test or positive stool antigen test no less than 4 weeks after completion of therapy AND c) member has confirmed clarithromycin-susceptible H. pylori (documentation required) OR B) Member has a documented intolerance or contraindication to one of the non-interchangeable components of quadruple therapy (i.e., tetracycline or metronidazole).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

APALUTAMIDE

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)
- OTEZLA XR
- OTEZLA XR INITIATION

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARIPIPRAZOLE FILM

Products Affected

- OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ASCIMINIB

Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ASENAPINE SUBLINGUAL

Products Affected

- *asenapine maleate*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ASENAPINE TRANSDERMAL

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AVMAPKI-FAKZYNJA

Products Affected

- AVMAPKI-FAKZYNJA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Acute Myeloid Leukemia (AML)-Initial: Approve if the member meets both A and B: A) Member achieved first complete remission (CR) or complete remission with incomplete blood count recover (CRi) following intensive induction chemotherapy AND B) Member is not able to complete intensive curative therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist, infectious disease specialist, or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	12 months
Other Criteria	Approve if the member has a positive culture for Pseudomonas aeruginosa in the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture). Member must be at least 7 years of age or older. Member must have FEV1 greater than or equal to 25% OR less than or equal to 75% predicted. Provider attests member is not colonized with Burkholderia cepacia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BEDAQUILINE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease physician or a pulmonologist
Coverage Duration	6 months
Other Criteria	Initial: Approve if the member has diagnosis of pulmonary tuberculosis (TB) due to Mycobacterium tuberculosis that is resistant to at least rifampin and isoniazid. Medication will not be used to treat latent, extra-pulmonary or drug-sensitive TB or for the treatment of infections caused by non-tuberculous mycobacteria. Must meet either A or B: A) Requested medication will be prescribed as part of a combination regimen with at least three other anti-tuberculosis agents the member's TB isolate has shown to be susceptible to in vitro OR if in vitro testing results are unavailable, the requested medication will be used in combination with at least 4 other drugs to which the member's TB isolate is likely to be susceptible OR B) Requested medication will be prescribed as part of a combination regimen known as BPaL that includes the use of the requested medication, pretomanid, and linezolid . Reauthorization: If a member requires treatment beyond the recommended timeframe, documentation from prescriber indicating the member's initial response to therapy and clinical rationale for continuation of treatment or for re-treatment must be provided. Chart note documenation of susceptibility testing of Mycobacterium tuberculosis isolates demonstrating continued susceptibility to the requested medication is required.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BELUMOSUDIL

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist, or transplant specialist
Coverage Duration	12 months
Other Criteria	Chronic Graft versus Host Disease (cGVHD)- Initial: Approve if the member has a diagnosis of cGVHD and has tried two or more conventional systemic treatments for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus). Reauthorization: Must have documentation from the provider that the condition has improved based upon the prescriber assessment while on therapy or the member continues to benefit from therapy. Requests for doses that exceed 200mg daily must meet both A and B: A) Documentation of a drug interaction with either a proton pump inhibitor (e.g., omeprazole, pantoprazole) or strong CYP3A inducer (e.g. rifampin, phenytoin, carbamazepine) AND B) Attestation from the provider that continued treatment with the interacting medication in combination with belumosudil (Rezurock) is medically necessary.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BELZUTIFAN

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEMPEDOIC ACID

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEMPEDOIC ACID/EZETIMIBE

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BENRALIZUMAB

Products Affected

- FASENRA PEN 10 MG/0.5 ML, 30 MG/ML
- FASENRA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEXAROTENE (ORAL)

Products Affected

- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEXAROTENE (TOPICAL)

Products Affected

- *bexarotene topical*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BOSENTAN

Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BOSUTINIB

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib oral tablet 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BOTOX

Products Affected

- BOTOX INJECTION RECON SOLN 100 UNIT, 200 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, rejuvenation of the peri-orbital region)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Migraine headache prevention-prescribed by, or after consultation with, a neurologist or HA specialist.
Coverage Duration	Authorization will be for 12 months
Other Criteria	Blepharospasm Associated with Dystonia or Strabismus-approve, Cervical Dystonia-approve, Hyperhidrosis, primary axillary-approve, Chronic low back pain after trial with at least 2 other pharmacologic therapies (eg, NSAID, antispasmodics, muscle relaxants, opioids, antidepressants) and if being used as part of a multimodal therapeutic pain management program. Essential tremor after a trial with at least 1 other pharmacologic therapy (eg, primidone, propranolol, benzodiazepines, gabapentin, topiramate), Migraine Headache Prevention-must have 15 or more migraine headache days per month with headache lasting 4 hours per day or longer (prior to initiation of Botox therapy) AND have tried at least two standard prophylactic pharmacologic therapies, each from a different pharmacologic class (e.g., beta-blocker, anticonvulsant, tricyclic antidepressant) and patient has had inadequate efficacy or adverse events. If the patient is currently taking Botox for migraine headache prevention, patient must have had significant clinical benefit. Overactive bladder with symptoms of urge urinary incontinence, urgency and frequency-approve if the patient has tried at least one other pharmacologic therapy. Spasticity, limb-approve. Urinary incontinence associated with a neurological condition-approve if the patient has tried at least one other pharmacologic therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Achalasia, Anal Fissure, Chronic facial pain/pain associated with TMJ dysfunction, Chronic low back pain, Dystonia, other than cervical, Essential tremor, Hyperhidrosis, gustatory, hyperhidrosis, Palmar/Plantar and facial, Myofascial pain, Ophthalmic disorders, other than blepharospasm or Strabismus, Sialorrhea, chronic, Spasticity, other than limb (i.e., due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm)
Part B Prerequisite	No
Prerequisite Therapy Required	No

BREXPIPRAZOLE

Products Affected

- REXULTI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BRIGATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BRIVARACETAM

Products Affected

- *brivaracetam oral solution*
- *brivaracetam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BUDESONIDE (TARPEYO)

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BUDESONIDE EC (UCERIS)

Products Affected

- *budesonide oral tablet,delayed and ext.release*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist
Coverage Duration	2 months
Other Criteria	Initial: Approve if member has a diagnosis of mild to moderate active ulcerative colitis and medication will be used to induce remission of active disease. Member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release prior to approval. Reauthorization: Must have documentation of concurrent maintenance treatment of ulcerative colitis and either clinical rationale from prescriber for continuation of treatment beyond 8 weeks or documentation that member is experiencing a subsequent flare-up and experienced improvement in the condition as a result of treatment with budesonide during a previous flare-up.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

BUPRENORPHINE (BUTRANS)

Products Affected

- *buprenorphine*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

C1 ESTERASE INHIBITOR (HAEGARDA)

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CABOZANTINIB (CABOMETYX)

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CABOZANTINIB (COMETRIQ)

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CALCIUM ACETATE

Products Affected

- *calcium acetate(phosphat bind) oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	Members on dialysis [non-D use]. Members on dialysis will have medication processed through the Part B Bundle.
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B versus Part D determination is made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an ESRD-related condition. Hyperphosphatemia: Approve if member has elevated serum phosphorus levels and has chronic kidney disease (CKD).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CAPIVASERTIB

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CARGLUMIC ACID

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CARIPRAZINE HCL

Products Affected

- VRAYLAR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CENOBAMATE

Products Affected

- XCOPRI MAINTENANCE PACK
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CERITINIB

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CHLORAMBUCIL

Products Affected

- LEUKERAN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CLOZAPINE SUSPENSION

Products Affected

- VERSACLOZ

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

COBIMETINIB

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Melanoma-Initial: Approve if the member has unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test. Medication must be used in combination with vemurafenib (Zelboraf). Histiocytic neoplasms-Initial: Approve if the member has diagnosis and will be using the requested medication as monotherapy. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician. Documentation required that disease progression has not occurred.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

CRISABOROLE

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	12 months
Other Criteria	Atopic Dermatitis-Initial: 3-23 months: Approve if member has tried and failed one prescription strength topical corticosteroid except where face, eyes, or genitalia are impacted. 2 years and older: Approve if member has tried and failed one prescription strength topical corticosteroid (except where face, eyes, or genitalia are impacted) AND one topical calcineurin inhibitor (i.e. pimecrolimus cream or tacrolimus ointment) unless the member has a documented intolerance or contraindication to aforementioned therapies. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CRIZOTINIB

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CRIZOTINIB PELLETS

Products Affected

- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CRYSVITA

Products Affected

- CRYSVITA

PA Criteria	Criteria Details
Exclusion Criteria	Chronic Kidney Disease (CKD), Severe Renal Impairment or End Stage Renal Disease
Required Medical Information	Diagnosis, lab values
Age Restrictions	TIO-2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or nephrologist (initial therapy)
Coverage Duration	XLH-1 year (initial/cont), TIO-initial-6 months, cont-1 year
Other Criteria	XLH-Initial therapy-Approve if the patient has had a baseline (prior to any XLH treatment) serum phosphorus level that was below the normal range for age and patient meets ONE of the following (a or b): a) The patient has had a baseline (i.e., prior to any XLH treatment tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) that was below the normal range for age and gender OR b) The patient has had a genetic test confirming the diagnosis of X-linked hypophosphatemia via identification of a PHEX mutation AND if the patient is greater than or equal to 18 years of age, the patient is currently exhibiting one or more signs or symptoms of XLH. Continuation-approve if the patient is continuing to derive benefit as determined by the prescribing physician. TIO-approve if the patient has a mesenchymal tumor that cannot be curatively resected or identified/localized AND the patient is currently exhibiting one or more signs or symptoms of TIO AND patient has had a baseline (prior to any TIO treatment) serum phosphorus level that was below the normal range for age AND patient has had a baseline (prior to any TIO treatment) tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) that was below the normal range for age and gender. Cont-approve if the patient is continuing to derive benefit as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

CYSTEAMINE (OPHTHALMIC)

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
Coverage Duration	12 months
Other Criteria	Approve if the member has corneal cysteine crystal deposits confirmed by slit-lamp examination.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

CYSTEAMINE (ORAL)

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DABRAFENIB

Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	Moderate to severe renal impairment (CrCl less than or equal to 50 mL/min), history of seizure, concomitant use with other forms of 4-aminopyridine
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or multiple sclerosis specialist
Coverage Duration	12 months
Other Criteria	Initial-Approve if the member is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with multiple sclerosis, and the member has impaired ambulation as evaluated by an objective measure (e.g., timed 25 foot walk and multiple sclerosis walking scale-12). Reauthorization-Approve if the member continues to meet all the initial criteria and has responded to or is benefiting from therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DASATINIB

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DEFERASIROX

Products Affected

- *deferasirox oral tablet*
- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DENOSUMAB (JUBBONTI)

Products Affected

- JUBBONTI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.

PA Criteria	Criteria Details
Other Criteria	Osteoporosis-Initial: Approve if used to treat osteoporosis in a member that is a post-menopausal female or male (Note: female and male are defined as an individual with the biological traits of a female or male, regardless of the individual's gender identity or gender expression) AND member meets one of the following A, B, C, or D: A) Member has had inadequate response after 6 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, B) Member cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, C) Member has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR D) Member has severe renal impairment (e.g., CrCl less than 35 mL/min) or CKD, or if the member has an osteoporotic fracture or fragility fracture . Androgen Deprivation Therapy (ADT) Bone Loss-Initial: Approve if member is receiving ADT (e.g., leuprolide, triptorelin, goserelin) for non-metastatic prostate cancer and at high risk for fracture or the patient has undergone a bilateral orchiectomy. Aromatase Inhibitor (AI) Bone Loss-Initial: Approve if member is receiving adjuvant AI therapy (e.g., anastrozole, letrozole, exemestane) for breast cancer and at high risk for fracture. Glucocorticoid-Induced Osteoporosis (GIO)-Initial: Approve if member meets either A, B, C, or D: A) Member tried and failed or has a contraindication (i.e., unable to swallow, difficulty swallowing, inability to remain upright post-administration, pre-existing GI medical condition [e.g., esophageal lesions or ulcers, abnormalties that delay esophageal emptying] one oral bisphosphonate, B) Member has tried zoledronic acid (Reclast), C) Member has severe renal impairment (e.g., CrCl less than 35 mL/min) or CKD, OR D) Member has an osteoporotic fracture or fragility fracture. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DENOSUMAB (WYOST)

Products Affected

- WYOST

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR
- AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DEXTROMETHORPHAN HBR/BUPROPION

Products Affected

- AUVELITY ORAL TABLET, IR AND ER, BIPHASIC

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DEXTROMETHORPHAN HBR/QUINIDINE

Products Affected

- *dextromethorphan-quinidine*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DIABETIC SUPPLIES (ALCOHOL PADS)

Products Affected

- *alcohol pads*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIABETIC SUPPLIES (GAUZE)

Products Affected

- GAUZE PADS 2 X 2

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIABETIC SUPPLIES (PEN NEEDLES)

Products Affected

- INSULIN PEN NEEDLE 29 GAUGE X 1/2"

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIABETIC SUPPLIES (SYRINGES)

Products Affected

- INSULIN SYRINGE (DISP) U-100 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DIAZEPAM (VALTOCO)

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DICLOFENAC SODIUM (DROPS)

Products Affected

- *diclofenac sodium topical drops*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	2 months
Other Criteria	Initial: Approve if the member has a diagnosis of osteoarthritis of the knee(s). Member must have a trial and failure or contraindication to at least two of the following: diclofenac sodium, meloxicam tablets, naproxen. Provider must attest the lowest effective dose and shortest duration of treatment will be utilized. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DICLOFENAC SODIUM (TOPICAL)

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DIHYDROERGOTAMINE MESYLATE

Products Affected

- *dihydroergotamine injection*
- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension. Ischemic heart disease (e.g. angina pectoris, history of myocardial infarction, or documented silent ischemia), or clinical symptoms or findings consistent with coronary artery vasospasms including Prinzmetal's variant angina. Concomitant use with potent CYP3A4 inhibitors, such as protease inhibitors and macrolide antibiotics (e.g. ritonavir, nelfinavir, erythromycin, clarithromycin, ketoconazole, itraconazole, etc). Use within 24 hours of ergotamine-containing or ergot-type medications or methysergide. Treatment of hemiplegic or basilar migraines. Known peripheral arterial disease, sepsis, following vascular surgery, and severely impaired hepatic or renal function. Pregnancy or nursing mothers. Concomitant use with peripheral and central vasoconstrictors
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has diagnosis of acute migraine with or without aura. Must not be used for the prophylactic therapy of migraines. Must have trials of two different formulary triptans with inadequate responses or significant side effects/toxicity unless contraindicated. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has relapsing form of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DORDAVIPRONE

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DORNASE ALFA

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DRONEDARONE

Products Affected

- MULTAQ

PA Criteria	Criteria Details
Exclusion Criteria	Permanent atrial fibrillation (sinus rhythm will never be restored), recently decompensated heart failure requiring hospitalization or Class IV heart failure, second or third-degree atrioventricular (AV) block or sick sinus syndrome (except when used in conjuction with a functioning pacemaker), bradycardia less than 50 bpm, concomitant use of a strong CYP3A inhibitor or drugs and herbal products that prolong the QT interval and may induce torsade de pointes, severe hepatic impairment, QTc Bazett interval greater than or equal to 500ms, pregnancy or nursing mothers
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member is in sinus rhythm and has a history of paroxymal or persistent atrial fibrillation (AF). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

DROXIDOPA

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DULAGLUTIDE (TRULICITY)

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DULOXETINE HCL (SPRINKLE CAPSULE)

Products Affected

- DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DUPILUMAB

Products Affected

- DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML
- DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ELACESTRANT

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ELAPEGADEMASE (REVCOVI)

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, hematologist or oncologist
Coverage Duration	12 months
Other Criteria	Approve if the member has Severe Combined Immunodeficiency Disease (SCID) with a definitive diagnosis of Adenosine Deaminase Deficiency as determined by one of the following A or B: A) Deficient ADA catalytic activity (less than 1% of normal) in hemolysates (in untransfused individuals) or in extracts of other cells (e.g., blood mononuclear cells, fibroblasts) OR B) Detection of pathogenic mutations in the ADA gene by molecular genetic testing. Member must have a marked elevation of the metabolite dATP or total dAdo nucleotides (the sum of dAMP, dADP and dATP) in erythrocytes. Reauthorization: Approve if the member has responded positively to therapy with stabilization in condition as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

ELEXACAFTOR/TEZACAFTOR/IVACAFTOR

Products Affected

- TRIKAFTA ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ELTROMBOPAG OLAMINE

Products Affected

- *eltrombopag olamine oral powder in packet 12.5 mg, 25 mg*
- *eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENCORAFENIB

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENSARTINIB

Products Affected

- ENSACOVE ORAL CAPSULE 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENTRECTINIB

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENZALUTAMIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EPOETIN ALFA

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERDAFITINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERENUMAB

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ESLICARBAZEPINE ACETATE

Products Affected

- *eslicarbazepine oral tablet 200 mg, 400 mg, 600 mg, 800 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of partial-onset seizures (i.e. focal seizures). Member must have tried and failed or have a contraindication to two or more generic formulary antiepileptic medications used to treat the same indication: levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin, or topiramate. Provider must attest the member will not be taking the medication concomitantly with oxcarbazepine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ETANERCEPT

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ETRASIMOD

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EVEROLIMUS

Products Affected

- *everolimus (antineoplastic) oral tablet*
- *yulithira*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EVEROLIMUS (AFINITOR DISPERZ)

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EVOLOCUMAB

Products Affected

- REPATHA
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FECAL MICROBIO SPORE,LIVE-BRPK

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FELBAMATE (SUSPENSION)

Products Affected

- *felbamate oral suspension*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FENTANYL (TRANSDERMAL)

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FIDAXOMICIN

Products Affected

- DIFICID ORAL SUSPENSION FOR RECONSTITUTION
- *fidaxomicin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	10 Days
Other Criteria	Approve if member has a diagnosis of Clostridium difficile based on a positive stool test. Reauthorization: Approve if member has a positive stool test within 8 weeks after completion of therapy for a prior CDI episode, for which symptoms and signs resolved.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

FILGRASTIM (ZARXIO)

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FILGRASTIM-AAFI (NIVESTYM)

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FINERENONE

Products Affected

- KERENDIA ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FINGOLIMOD

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS). Recent myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure. History of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless member has a pacemaker. Baseline QTc interval greater than or equal to 500 msec. Cardiac arrhythmias requiring anti-arrhythmic treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or an MS specialist
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member is at least 10 years of age and has a diagnosis of relapsing multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

FLUCONAZOLE (IV)

Products Affected

- *fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FLUCYTOSINE

Products Affected

- *flucytosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consulation with an infectious disease specialist
Coverage Duration	6 weeks
Other Criteria	Initial: Approve if member has a serious infection caused by a susceptible strain of Candida or Cryptococcus (documentation required). Member will be using the requested medication with another antifungal agent (i.e. amphotericin B). Reauthorization: Additional authorizations for treatment are made on a case-by-case basis, are subject to the above criteria, and require chart documentation describing the previous response and clinical rationale for re-treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FLUTAMIDE

Products Affected

- EULEXIN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FRUQUINTINIB

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FUTIBATINIB

Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GALCANEZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GANAXOLONE

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GEPIRONE HCL

Products Affected

- EXXUA ORAL TABLET EXTENDED RELEASE 24 HR
- EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GLASDEGIB MALEATE

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Acute Myeloid Leukemia (AML)-Initial: Approve if the member meets all the criteria A, B, C: A) Medication will be used in combination with cytarabine, B) the member is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, and C) medication will be used as a treatment for induction therapy, postinduction/consolidation therapy, or relapsed or refractory disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLATIRAMER

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of relapsing forms of multiple sclerosis (RRMS). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLECAPREVIR/PIBRENTASVIR

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	Genotype (including unknown)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLUTAMINE

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IBERDOMIDE

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ICATIBANT ACETATE (ICATIBANT)

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ICATIBANT ACETATE (SAJAZIR)

Products Affected

- *sajazir*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ILOPERIDONE

Products Affected

- FANAPT
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B
- FANAPT TITRATION PACK C

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMATINIB (IMKELDI)

Products Affected

- IMKELDI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMLUNESTRANT

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INAVOLISIB

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INFLIXIMAB-DYYB (ZYMFENTRA)

Products Affected

- ZYMFENTRA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INTERFERON BETA-1A

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or an MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of relapsing forms of multiple sclerosis (RRMS) and has had a trial and failure of one formulary generic medication used for the same indication (e.g., dimethyl fumarate, glatiramer, teriflunomide). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INTERFERON BETA-1B

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or an MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of relapsing forms of multiple sclerosis (RRMS) and has had a trial and failure of one formulary generic medication used for the same indication (e.g., dimethyl fumarate, glatiramer, teriflunomide). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

INTERFERON GAMMA-1B (ACTIMMUNE)

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	Simultaneous administration of requested medication with other heterologous serum protein or immunological preparations (e.g., vaccines)
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Chronic Granulomatous Disease: Prescribed by or in consultation with an immunologist, hematologist, or an infectious diseases specialist. Malignant osteopetrosis: Prescribed by or in consultation with an endocrinologist or hematologist.
Coverage Duration	12 months
Other Criteria	Chronic Granulomatous Disease (CGD)-Initial: Approve if diagnosis has been established by one of the following tests: Nitroblue tetrazolium test (negative), Dihydrorhodamine test (DHR + neutrophils less than 95 percent), a molecular genetic test identifying a gene-related mutation linked to chronic granulomatous disease or immunoblot positive for p22phox, p40phox, p47phox, p67phox, or gp91phox. Must have a trial and failure of trimethoprim/sulfamethoxazole AND itraconazole or an intolerance or contraindication to those therapies. Severe Malignant Osteopetrosis (SMO)-Initial: Approve if patient has diagnosis has been established by a molecular genetic test identifying a gene-related mutation linked to severe malignant osteopetrosis OR radiographic (X-ray) imaging demonstrating skeletal features related to osteopetrosis. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ISAVUCONAZONIUM (ORAL)

Products Affected

- CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ISOCARBOXAZID

Products Affected

- MARPLAN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IVABRADINE

Products Affected

- *ivabradine*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IVACAFTOR

Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IVERMECTIN (ORAL)

Products Affected

- *ivermectin oral tablet 3 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Provider must attest medication will not be used for the treatment of COVID-19. Requested medication has not been approved for this use given no evidence of improving health outcomes for those infected with COVID-19 has been established in clinical trials.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

IVIG (GAMUNEX-C)

Products Affected

- GAMASTAN GRAM/10 ML (10 %)
- GAMUNEX-C INJECTION SOLUTION 1

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LAMOTRIGINE SUSPENSION

Products Affected

- SUBVENITE ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LAZERTINIB

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEDIPASVIR/SOFOSBUVIR

Products Affected

- LEDIPASVIR-SOFOSBUVIR

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	Genotype (including unknown)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance
Part B Prerequisite	No
Prerequisite Therapy Required	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LENVATINIB

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LETERMOVIR

Products Affected

- PREVYMIS ORAL PELLETS IN PACKET
- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEUPROLIDE ACETATE

Products Affected

- *leuprolide subcutaneous kit*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Cancer/CPP: 12 months, Endometriosis: 6 months, Fibroids: 3 months
Other Criteria	For all diagnoses: Dose must not exceed FDA labeling for diagnosis requested including, but not limited to, appropriate formulation for diagnosis, strength, and duration.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

LEVETIRACETAM (SPRITAM)

Products Affected

- SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEVOMILNACIPRAN HCL

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LIDOCAINE PATCH

Products Affected

- *dermacinrx lidocan*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocan iii*
- *lidocan iv*
- *lidocan v*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if member has diagnosis of pain associated with post-herpetic neuralgia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIRAGLUTIDE (VICTOZA)

Products Affected

- *liraglutide*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LOTILANER

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LUMACAFTOR/IVACAFTOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LUMATEPERONE TOSYLATE

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MARIBAVIR

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MECHLORETHAMINE

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MEGESTROL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEMANTINE

Products Affected

- *memantine oral capsule,sprinkle,er 24hr*
- *memantine oral solution*
- *memantine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEPOLIZUMAB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MERCAPTOPURINE SUSPENSION

Products Affected

- *mercaptopurine oral suspension*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

METHADONE

Products Affected

- *methadone intensol*
- *methadone oral concentrate*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *methadose oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member has a diagnosis of pheochromocytoma and member has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MIDAZOLAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
Coverage Duration	12 months
Other Criteria	Endogenous Cushing's Syndrome-Initial: Approve if the requested medication is being used to control hyperglycemia secondary to hypercortisolism in members who have type 2 diabetes mellitus or glucose intolerance and member meets either A, B, or C: A) Member is not a candidate for surgery or surgery has not been curative, B) member is awaiting surgery for endogenous Cushing's Syndrome, OR C) Member is awaiting therapeutic response after radiotherapy for endogenous Cushing's Syndrome. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, Sjogren-Larsson-Syndrome
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	30 Days
Other Criteria	Initial: Approve if member is 12 years or older and weighs greater than or equal to 30 kg (66 lbs). Member must have a diagnosis of one of the following confirmed using methods such as histopathology, parasite isolation by in vitro culture, polymerase chain reaction, molecular detection of parasite DNA, serologic testing (visceral leishmaniasis): (1) Visceral leishmaniasis due to Leishmania donovani, (2) Cutaneous leishmaniasis due to Leishmania braziliensis, Leishmania guyanensis, and Leishmania panamensis, or (3) Mucosal leishmaniasis due to Leishmania braziliensis. Must have a trial and failure, contraindication or intolerance to Liposomal Amphotericin B prior to approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	Yes
Prerequisite Therapy Required	No

MIRDAMETINIB

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG SUSPENSION
- GOMEKLI ORAL TABLET FOR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MITOTANE

Products Affected

- LYSODREN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MOMELOTINIB

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MORPHINE SULFATE ER

Products Affected

- *morphine oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NILOTINIB (DANZITEN)

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NILOTINIB (TASIGNA)

Products Affected

- *nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NILUTAMIDE

Products Affected

- *nilutamide*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NINTEDANIB

Products Affected

- *nintedanib*
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NIRAPARIB TOSYLATE

Products Affected

- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NIRAPARIB/ABIRATERONE

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NIROGACESTAT

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NITISINONE

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NOVOFINE DIABETIC SUPPLIES

Products Affected

- NEEDLES, INSULIN DISP.,SAFETY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Clinical rationale why the member is unable to use the preferred product (i.e. BD Autoshield Duo Needle 5mm x 30G, BD Autoshield Duo Pen Needle 5mm x 30G) must be submitted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OCTREOTIDE (INJECTABLE)

Products Affected

- *octreotide acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly: Prescribed by or in consultation with an endocrinologist. Carcinoid tumor, VIP-secreting tumor: Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Acromegaly-Initial: Approve if the member has a confirmed diagnosis of acromegaly with elevated serum IGF-1 for age/gender (test results with reference range required) or elevated growth hormone level greater than or equal to 1 ng/mL during an oral glucose intolerance test (test result with reference range required). Member must have inadequate response to surgery or documentation that this therapy is inappropriate. Severe Diarrhea and Flushing-Initial: Approve if the member has severe diarrhea and flushing associated with a metatstatic carcinoid tumor. Profuse Watery Diarrhea-Initial: Approve if the member has profuse watery diarrhea associated with Vasoactive Intestinal Peptide Tumors (VIPomas). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

OLANZAPINE/SAMIDORPHAN

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OLAPARIB

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OLUTASIDENIB

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OMALIZUMAB

Products Affected

- XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML
- XOLAIR SUBCUTANEOUS RECON SOLN
- XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PALBOCICLIB

Products Affected

- IBRANCE ORAL CAPSULE 125 MG
- IBRANCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PASIREOTIDE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	Severe Hepatic impairment (Child-Pugh C)
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's Disease
Coverage Duration	12 months
Other Criteria	Cushing's Disease-Initial: Member must have diagnosis of Cushing's Disease and meet the following (A, B, C, and D): A) Previously had pituitary surgery (e.g., transsphenoidal surgery) that was not curative or must not be a candidate for surgery, B) Must provide a baseline 24-hour urinary free cortisol level, C) Must have recent (within 6 months) baseline assessment of hemoglobin A1C and provide documentation of anti-diabetic therapy if baseline hemoglobin is greater than 8%, AND D) Documention showing confirmation that the source of Cushing's Disease is pituitary. Reauthorization: Documentation of positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

PAZOPANIB

Products Affected

- *pazopanib oral tablet 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PEGINTERFERON BETA-1A

Products Affected

- PLEGRIDY INTRAMUSCULAR
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or an MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of relapsing forms of multiple sclerosis (RRMS) and has had a trial and failure of one formulary generic medication used for the same indication (e.g., dimethyl fumarate, glatiramer, teriflunomide). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEGVISOMANT

Products Affected

- SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	Acromegaly-Initial: Approve if the member has a confirmed diagnosis of acromegaly with the following baseline labs (test result with reference range required): elevated serum IGF-1 level for gender/age OR an elevated growth hormone level defined as GH at least 1ng/mL during oral glucost tolerance test. Member must have inadequate response to surgery or documentation that this therapy is inappropriate. Trial and failure or contraindication to a dopamine agonist (i.e. bromocriptine) or somatostatin analogue (i.e. octreotide) prior to approval is required. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PERAMPANEL

Products Affected

- *perampanel oral suspension* *4 mg, 6 mg, 8 mg*
- *perampanel oral tablet 10 mg, 12 mg, 2 mg,*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PEXIDARTINIB

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of any other phenylbutyrate product
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a provider who specializes in the treatment of inherited metabolic disorders
Coverage Duration	12 months
Other Criteria	Initial: Member must have diagnosis of urea cycle disorder confirmed by either A or B: A) Member had a genetic test confirm a mutation resulting in a urea cycle disorder (test result requred) OR B) hyperammonemia with ammonia levels above the upper limit of normal (test result with reference range required). Member must have disease that cannot be managed by protein restriction or amino acid supplemenation alone. Medication will be used in combination with dietary protein restriction. Reauthorization: Approve if documenation from provider indicates improvement in condition based on decreased ammonia levels while on therapy and medication will continue to be used in combination with a protein restricted diet.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

PIMAVANSERIN TARTRATE

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PIMECROLIMUS (TOPICAL)

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member has a diagnosis of atopic dermatitis. Member must have a trial and failure or contraindication to a moderate to high potency topical corticosteroid (Note: Potency exceptions may be made for members with dermatitis affecting the face or intertriginous areas) and topical tacrolimus ointment. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PIRFENIDONE

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PIRTOBRUTINIB

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

POMALIDOMIDE

Products Affected

- *pomalidomide*
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PONATINIB

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

POSACONAZOLE (ORAL)

Products Affected

- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with CYP3A4 substrates that prolong the QT interval (e.g., pimozide, quinidine), sirolimus, HMG-CoA reductase inhibitors that are primarily metabolized through CYP3A4 (e.g., atorvastatin, lovastatin, simvastatin), ergot alkaloids, venetoclax at initiation and during the ramp-up phase in patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Prophylaxis-Initial: Member must be using medication as prophylaxis against invasive aspergillus and candida infections. Member must be severely immunocompromised (i.e. hematopoietic stem cell transplant [HSCT], recipient with graft vs host disease [GvHD], or members with prolonged neutropenic from chemotherapy for hematologic malignancies such as acute myelogenous leukemia [AML] or myelodysplastic syndromes [MDS]). Reauthorization: Members requiring further treatment will be reassessed using the initial criteria.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

PRALSETINIB

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PRETOMANID

Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease physician or a pulmonologist
Coverage Duration	6 months
Other Criteria	Initial: Approve if the member has diagnosis of pulmonary tuberculosis (TB) due to Mycobacterium tuberculosis that is resistant to at least rifampin and isoniazid. Medication will not be used to treat latent, extra-pulmonary or drug-sensitive TB or for the treatment of infections caused by non-tuberculous mycobacteria. Medication will not be used to treat tuberculosis that is resistant to isoniazid and rifampin when responsive to standard therapy and NOT treatment-intolerant. Requested medication must be prescribed as part of a combination known as BPaL regimen or BPaLM regimen, including bedaquiline, pretomanid, and linezolid, with or without moxifloxacin. Reauthorization: If a member requires treatment beyond the recommended timeframe, documentation from prescriber indicating the member's initial response to therapy and clinical rationale for continuation of treatment or for re-treatment must be provided. Chart note documenation of susceptibility testing of Mycobacterium tuberculosis isolates demonstrating continued susceptibility to the requested medication is required.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

PROCARBAZINE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious diseases specialist
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

QUIZARTINIB

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RELACORILANT (LIFYORLI)

Products Affected

- LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9), 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RELUGOLIX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

REPOTRECTINIB

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RESMETIROM

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

REVUMENIB

Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIBOCICLIB SUCCINATE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RILONACEPT

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RILUZOLE

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIMEGEPANT SULFATE

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RISANKIZUMAB (SKYRIZI)

Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 55 MG/0.37 ML
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ROFLUMILAST

Products Affected

- *roflumilast*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ROPEGINTERFERON ALFA-2B

Products Affected

- BESREMI
- BESREMI PEN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RUFINAMIDE

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RUXOLITINIB

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SANDOSTATIN LAR

Products Affected

- *octreotide,microspheres*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous treatments/therapies
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly-prescr/consult w/endocrinologist. All neuroendocrine tumors-prescr/consult w/oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescr/consult w/endo/onc/neuro.Meningioma-prescr/consult w/oncologist, radiologist or neurosurgeon. Merkel cell/Thymoma/Thymic carcinoma-prescr/consult w/oncologist. Diarrhea assoc w chemo-presc/consult oncologist/gastro.
Coverage Duration	Enterocutaneous fistula/diarrhea assoc w chemo - 3 months, all others - 1 year
Other Criteria	Acromegaly-approve if the patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory AND the patient meets i., ii., or iii: i. has had an inadequate response to surgery and/or radiotherapy or ii. is not an appropriate candidate for surgery and/or radiotherapy or iii. the patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). Diarrhea assoc w chemo (A and B): A) grade 3 or 4 diarrhea and B) patient has tried at least one antimotility medication. Merkel cell carcinoma (A and B): A) patient has regional or distant metastatic disease and B) has contraindications to or has progressed on checkpoint immunotherapy. Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas)-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Pheochromocytoma/paraganglioma, Meningioma, Thymoma and thymic carcinoma, enterocutaneous fistulas, diarrhea associated with chemotherapy, Merkel cell carcinoma

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

SAPROPTERIN

Products Affected

- *sapropterin*
- *zelvysia*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SARGRAMOSTIM

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Acute myeloid leukemia (AML) following induction chemotherapy-Initial: Approve if member meets A and B: A) Member is 55 years of age or older AND B) Medication is being used to shorten time to neutrophil recovery and to reduce the incidence of severe and life-threatening infections. Autologous Peripheral Blood Progenitor Cell Mobilization and Collection-Initial: Approve if member is an adult and meets A and B: A) The medication is being used for the mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis AND B) Member has cancer and undergoing autologous hematopoietic stem cell transplantation. Autologous Peripheral Blood Progenitor Cell and Bone Marrow Transplantation-Initial: Approve if member meets all A, B AND C: A) Member is 2 years of age and older, B) Therapy is needed for faster reconstitution of myeloid following an autologous peripheral blood progenitor cell transplant or bone marrow transplant. AND C) Member has one of the following: non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL) or Hodgkin's lymphoma (HL). Allogeneic Bone Marrow Transplantation-Initial: Approve if member meets A AND B: A) Member is 2 years of age and older AND B) Member is undergoing allogeneic bone marrow transplantation from HLA-matched related donors. Treatment of Delayed Neutrophil Recovery or Graft Failure-Initial: Approve if member meets all A, B AND C: A) Member is 2 years of age and older, B) Member has undergone allogeneic or autologous bone marrow transplantation, AND C) There is delayed or failed neutrophil recovery. Acute Exposure to Myelosuppressive Doses of Radiation (H-ARS)-Initial: Approve if member has been acutely exposed to myelosuppressive doses of radiation. Neuroblastoma: Initial: Approve if the member has high-risk neuroblastoma and is being treated with a GD2-binding monoclonal antibody (e.g., dinutuximab or naxitamab) indicated in combination with a granulocyte-macrophage colony-stimulating factor (GMCSF). Reauthorization-All: Must have documentation from prescriber indicating improvement in condition.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neuroblastoma
Part B Prerequisite	No
Prerequisite Therapy Required	No

SECUKINUMAB

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELEGILINE (EMSAM)

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELEXIPAG

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 100 MCG, 150 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELPERCATINIB

Products Affected

- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SELUMETINIB GRANULE

Products Affected

- KOSELUGO ORAL CAPSULE, SPRINKLE 5 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEMAGLUTIDE INJECTABLE (OZEMPIC)

Products Affected

- OZEMPIC SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEMAGLUTIDE INJECTABLE (WEGOVY)

Products Affected

- WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEMAGLUTIDE TABLET (OZEMPIC)

Products Affected

- OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEMAGLUTIDE TABLET (WEGOVY)

Products Affected

- WEGOVY ORAL

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEVABERTINIB

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SEVELAMER CARBONATE

Products Affected

- *sevelamer carbonate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Members on dialysis [non-D use]. Members on dialysis will have medication processed through the Part B Bundle.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B versus Part D determination is made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an ESRD-related condition. Hyperphosphatemia: Approve if member has elevated serum phosphorus levels and has chronic kidney disease (CKD).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Hyperphosphatemia
Part B Prerequisite	No
Prerequisite Therapy Required	No

SILDENAFIL (PAH)

Products Affected

- *sildenafil (pulmonary arterial hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SODIUM OXYBATE

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOFOSBUVIR/VELPATAS/VOXILAPREV

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOFOSBUVIR/VELPATASVIR

Products Affected

- SOFOSBUVIR-VELPATASVIR

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype (including unknown)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance
Part B Prerequisite	No
Prerequisite Therapy Required	No

SOMATROPIN

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SORAFENIB

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOTATERCEPT

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOTORASIB

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Initial: Approve if the member has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an FDA-approved test AND has been previously treated with at least one systemic regimen. Metastatic Colorectal Cancer (mCRC)-Approve if member meets all the following A, B, and C: A) Member has diagnosis of KRAS G12C-mutated mCRC as determined by an FDA-approved test, B) Member will be receiving requested medication in combination with panitumumab (Vectibix), and C) Member has received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SPARSENTAN

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

STIRIPENTOL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

STRENSIQ

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, genetic and lab test results
Age Restrictions	Disease onset-less than or equal to 18
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of hypophosphatasia or related disorders.
Coverage Duration	1 year
Other Criteria	Hypophosphatasia - Perinatal/Infantile- and Juvenile-Onset-Patient must meet both A and B for approval. A) Diagnosis is supported by one of the following (i, ii, or iii): i. Molecular genetic testing documenting tissue non-specific alkaline phosphatase (ALPL) gene mutation OR ii. Low baseline serum alkaline phosphatase activity OR iii. An elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, urinary phosphoethanolamine) AND B) Patient meets one of the following (i or ii): i. Patient currently has, or has a history of clinical manifestations consistent with hypophosphatasia (e.g., skeletal abnormalities, premature tooth loss, muscle weakness, poor feeding, failure to thrive, respiratory problems, Vitamin B6-dependent seizures) OR ii. Patient has a family history (parent or sibling) of hypophosphatasia without current clinical manifestations of hypophosphatasia
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TACROLIMUS (TOPICAL)

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member has a diagnosis of atopic dermatitis. Member must have a trial and failure or contraindication to a topical corticosteroid. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TACROLIMUS XR (ENVARSUS)

Products Affected

- ENVARSUS XR

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TADALAFIL (BPH)

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Use for erectile dysfunction (ED) without the signs and symptoms of benign prostatic hyperplasia (BPH). Concomitant use of nitrate products or guanylate cyclase (GC) stimulators.
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member has a diagnosis of benign prostatic hyperlasia (BPH) and had a trial and failure or documented contraindication to an alpha blocker (e.g. tamsulosin, alfuzosin) and a 5-alpha reductase inhibitor (e.g. finasteride, dutasteride). Medication will be dosed once daily. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TADALAFIL (PAH)

Products Affected

- *tadalafil (pulmonary arterial hypertension) oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TALAZOPARIB

Products Affected

- TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TALETRECTINIB

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TAMOXIFEN SOLUTION

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Exclusion Criteria	Members who require concomitant warfarin therapy or have a history of deep vein thrombosis or pulmonary embolus, if the indication for treatment is either reduction of breast cancer incidence in high-risk patients or risk reduction of invasive breast cancer after treatment of DCIS.
Required Medical Information	Diagnosis and must have documentation showing that administration via nasogastric tube is required OR documentation of inability to swallow an intact tablet.
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TASIMELTEON

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TAZAROTENE

Products Affected

- *tazarotene topical cream 0.1 %*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TEDUGLUTIDE

Products Affected

- GATTEX 30-VIAL
- GATTEX ONE-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Initial: Approve if the member has carcinoid syndrome diarrhea and meets all the following (A, B, and C): A) Member has been on somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]), B) the member continues to have at least four bowel movements per day despite treatment with SSA therapy, AND C) Requested medication will be used concomitantly with a SSA therapy. Reauthorization: Approve if the member is continuing to take the requested medication with a SSA therapy for carcinoid syndrome diarrhea and has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TENOFOVIR (VEMLIDY)

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TEPOTINIB

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TERIFLUNOMIDE

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with leflunomide (Arava) or other disease-modifying agents used for multiple sclerosis (MS), severe hepatic impairment, and pregnancy
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	12 months
Other Criteria	Initial: Approve if the member has a diagnosis of relapsing multiple sclerosis (i.e. relapsing-remitting or active secondary progressive disease and clinically-isolatted syndrome). Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TESTOSTERONE (INJECTABLE)

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Delayed puberty or induction of puberty in males-12 years and older
Prescriber Restrictions	N/A
Coverage Duration	Delayed puberty or induction of puberty in males-6 months, All others-12 months
Other Criteria	Hypogonadism (primary or secondary) in males-Initial: Approve if the member meets all of the following criteria: 1) Member has persistent signs and symptoms of androgen deficiency prior to start of androgen therapy (i.e. depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido), 2) Member has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Delayed puberty or induction of puberty in males-Initial: Approve testosterone cypionate or enanthate. Breast cancer in females - Approve testosterone enanthate. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician and it is deemed necessary to continue treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

TESTOSTERONE (NON-INJECTABLE)

Products Affected

- *testosterone transdermal gel*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Hypogonadism (primary or secondary) in males-Initial: Approve if the member meets all of the following criteria: 1) Member has persistent signs and symptoms of androgen deficiency prior to start of androgen therapy (i.e. depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido), 2) Member has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician and it is deemed necessary to continue treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

TETRABENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

THALIDOMIDE

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

THIOGUANINE

Products Affected

- TABLOID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 months
Other Criteria	Approve if requested medication will be used for the remission induction and remission consolidation treatment of acute nonlymphocytic leukemias. Provider must attest medication will not be used during maintenance therapy or similar long term continuous treatments due to the high risk of liver toxicity.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TIRZEPATIDE (MOUNJARO)

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	Members with a personal or family history of Medullary Thyroid Cancer or member with Multiple Endocrine Neoplasia syndrome type 2 (MED 2).
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Glycemic Control-Initial: Approve if the member has a diagnosis of Type II Diabetes Mellitus (T2DM) confirmed by one of the following for the member within the previous 12 months (documentation required): A) Hemoglobin A1c (A1C) greater than or equal to 6.5%, B) Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL after fasting for at least 8 hours, C) 2-Hour plasma glucose is greater than or equal to 200 mg/dL as part of an oral glucose tolerance test (75g of oral glucose is consumed after fasting for at least 8 hours), OR D) chart note documentation confirming T2DM diagnosis. Provider must attest the member will use the medication in adjunct to diet and exercise. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TIVOZANIB

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOBRAMYCIN (NEBULIZATION)

Products Affected

- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Cystic fibrosis-Initial: Approve if the member has pseudomonas aeruginosa in the culture of the airway (documentation required).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOCILIZUMAB (TYENNE)

Products Affected

- TYENNE AUTOINJECTOR
- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOLVAPTAN (JYNARQUE)

Products Affected

- *tolvaptan (polycys kidney dis) oral tablet 15 mg, 30 mg*
- *tolvaptan (polycys kidney dis) oral tablets, sequential*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOLVAPTAN (SAMSCA)

Products Affected

- *tolvaptan oral tablet 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications containing tolvaptan, strong CYP3A inhibitors, or hypertonic saline. Members requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms. Use in members with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS. Members who are unable to respond appropriately to thirst. Hypovolemic hyponatremia and anuria.
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	30 days

PA Criteria	Criteria Details
Other Criteria	Approve if the member has clinically significant hypervolemic and euvolemic hyponatremia defined as serum sodium less than 125 mEq/L at baseline or less marked hyponatremia (i.e., serum sodium less than 135 mEq/L at baseline) that is symptomatic (e.g., nausea, vomiting, headache, lethargy, confusion) and has resisted correction with fluid restriction. Provider must have consideration of discontinuation of agents known to cause Syndrome of Inappropriate Antidiuretic Hormone (SIADH) when clinically feasible (e.g. chlorpropamide, selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, clofibrate, carbamazepine, vincristine, nicotine, narcotics, phenothiazines, butyrophenones, ifosfamide, cyclophosphamide, NSAIDs, MDMA, desmopressin, oxytocin, vasopressin, carbamazepine, oxcarbazepine). Must have CrCl greater than 10mL/min. Must be initiated and titrated in hospital setting with close serum sodium monitoring. Must be able to sense and appropriately respond to thirst. If SIADH is underlying cause of hyponatremia, the member must demonstrate all of the following: decreased plasma osmolality of less than 275 mosm/kg, increased urinary osmolality of greater than 100mosm/kg during hypotonicity, urinary sodium greater than 20mmol/L with normal dietary salt intake, clinical euvolemia, normal thyroid and adrenal function, and no recent use of diuretics within 24 hours of laboratory testing.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOPIRAMATE SOLUTION

Products Affected

- *topiramate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOVORAFENIB

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET 400 MG/WEEK

(100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRALOKINUMAB

Products Affected

- ADBRY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRAMETINIB

Products Affected

- MEKINIST ORAL RECON SOLN
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRAZODONE SOLUTION

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRETINOIN (TOPICAL)

Products Affected

- *tretinoin topical*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic diagnoses are not covered (i.e. solar elastosis, sun damage, wrinkles, actinic damage, melasma, lentigines or freckles, hyperpigmented macules, liver spots, heliodermatosis, dermatoheliosis)
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Initial: Approve if member has a diagnosis of acne vulgaris. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRIENTINE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

UPADACITINIB

Products Affected

- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

UPADACITINIB LIQUID

Products Affected

- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

USTEKINUMAB-KFCE (YESINTEK)

Products Affected

- YESINTEK INTRAVENOUS
- YESINTEK SUBCUTANEOUS SOLUTION
- YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VEDOLIZUMAB (ENTYVIO)

Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VENETOCLAX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VERICIGUAT

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VIGABATRIN

Products Affected

- *vigabatrin*
- *vigadrone*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VIMSELTINIB

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VORASIDENIB

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VORICONAZOLE (IV)

Products Affected

- *voriconazole intravenous recon soln*
- *voriconazole-hpbcd*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Active Invasive Aspergillosis-Initial: Approve. Serious infection caused by Scedosporium apiospermum or Fusarium species-Initial: Approve. Candida Infections-Initial: Approve if the member has tried and failed, has a contraindication or significant intolerance to fluconazole AND has a diagnosis of A, B, or C: A) esophageal candidiasis, B) candidemia in nonneutropenic patient, or C) other deep tissue Candida infections. Blastomycosis: Approve if the member has a diagnosis of blastomycosis AND has a contraindication or significant intolerance to itraconazole. Reauthorization: Member has a diagnosis of invasive Aspergillus, a serious infection caused by Scedosporium apiospermum or Fusarium species, esophageal candidiasis, candidemia in nonneutropenic member, other deep tissue Candida infections, or blastomycosis and patient has continued indicators of active disease (e.g., biomarkers in serum assay, microbiologic cultures, radiographic evidence).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VORICONAZOLE (ORAL)

Products Affected

- *voriconazole oral suspension for reconstitution*
- *voriconazole oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with rifampin, carbamazepine, long-acting barbiturates, efavirenz, ritonavir, rifabutin, ergot alkaloids, and St. Johns Wort due to risk of loss of efficacy. Coadministration with naloxegol, tolvaptan, finerenone and lurasidone due to risk of adverse reactions. Coadministration with venetoclax at initiation and during the ramp-up phase in patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) due to increased risk of adverse reactions. Coadministration with pimozide, quinidine, sirolimus or ivabradine due to risk of serious adverse reactions.
Required Medical Information	Diagnosis, For suspension: must have chart note documentation of the clinical rationale for why tablets cannot be used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Approve if the member has a diagnosis of either A, B, C, or D (Lab results and documentation required): A) invasive aspergillosis, B) candidemia in non-neutropenics and other deep tissue Candida infections, C) esophageal candidiasis, OR D) serious fungal infections caused by Scedosporium apiospermum and Fusarium species including Fusarium solani, in members intolerant of, or refractory to, other therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	No

VORINOSTAT

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VORTIOXETINE

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XANOMELINE TART/TROSPIUM CHLOR

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZANUBRUTINIB

Products Affected

- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Mantle Cell Lymphoma (MCL)-Initial: Approve if the member has tried at least one other therapy prior to requested medication. Marginal Zone Lymphoma-Initial: Approve if the member has relapsed or refractory disease after a trial and failure of at least one anti-CD20 based regimen prior to the requested medication. Chronic Lymphocytic Leukemia (CLL)/Small lymphocytic lymphoma (SLL) or Waldenstrom Macroglobulinemia (WM)- Initial: Approve. Chronic Lymphocytic Leukemia (CLL)/Small lymphocytic lymphoma (SLL)-Approve. Follicular Lymphoma (FL)-Initial: Approve if member has refractory or relapsed disease after a trial and failure of at least two or more systemic regimens prior to requested medication AND member will be using in combination with obinutuzumab (Gazyva).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ZIDESAMTINIB

Products Affected

- JIDEYTRO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZIFTOMENIB

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZONGERTINIB

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZONISAMIDE (SUSPENSION)

Products Affected

- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZURANOLONE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Part B Prerequisite	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PART B VERSUS PART D

Products Affected

- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml*
- *amphotericin b injection recon soln 50 mg*
- *amphotericin b liposome intravenous suspension for reconstitution 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*
- *aprepitant oral capsule,dose pack 125 mg (1)- 80 mg (2)*
- *arformoterol inhalation solution for nebulization 15 mcg/2 ml*
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION 5 %
- CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- CYCLOPHOSPHAMIDE ORAL TABLET 50 MG
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML
- ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML
- *everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG
- *gengraf oral capsule 100 mg, 25 mg*
- *granisetron hcl oral tablet 1 mg*
- HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML
- IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT
- *intralipid intravenous emulsion 20 %*
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml*
- JYLAMVO ORAL SOLUTION 2 MG/ML
- JYNNEOS (PF) SUBCUTANEOUS SUSPENSION 0.5X TO 3.95X 10EXP8 UNIT/0.5
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*
- *liraglutide (weight loss) subcutaneous pen injector 3 mg/0.5 ml (18 mg/3 ml)*
- *methotrexate sodium (pf) injection solution 25 mg/ml*
- *methotrexate sodium injection solution 25 mg/ml*
- *methotrexate sodium oral tablet 2.5 mg*
- *methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg*

- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension for reconstitution 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet,delayed release (dr/ec) 180 mg, 360 mg*
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 4 mg, 8 mg*
- *ondansetron oral tablet,disintegrating 4 mg, 8 mg*
- *pentamidine inhalation recon soln 300 mg*
- PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %
- *premasol 10 % intravenous parenteral solution 10 %*
- PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG
- RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML
- *sirolimus oral solution 1 mg/ml*
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- *travasol 10 % intravenous parenteral solution 10 %*
- TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- XATMEP ORAL SOLUTION 2.5 MG/ML
- YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML

Details

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

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