

# ACTEMRA

## Products Affected

- ACTEMRA INTRAVENOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD. Exclude for indication of COVID-19 treatment in hospitalized patients (ie, non-D use).
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, SJIA, PJIA, GCA - Prescribed by or in consultation with a rheumatologist (initial therapy).
<b>Coverage Duration</b>	Approve through end of plan year
<b>Other Criteria</b>	RA initial - approve if the patient meets one of the following (A or B): A) patient has tried TWO of the following drugs in the past: Enbrel, a preferred adalimumab product, Orencia, Rinvoq or Xeljanz/XR (Note: if the patient does not meet this requirement, previous trial(s) with the following drugs will be counted towards meeting the try TWO requirement: Cimzia, Kevzara, infliximab, golimumab SC/IV, or a non-preferred adalimumab product will also count.). OR B) patient has heart failure or a previously treated lymphoproliferative disorder. PJIA, initial-approve if the patient meets one of the following (A or B): A) patient has tried TWO of the following drugs in the past: Enbrel, Orencia, Rinvoq, Xeljanz or a preferred adalimumab product. (Note: if the patient does not meet this requirement, a previous trial with the drug Kevzara, infliximab or a non-preferred adalimumab product will be counted towards meeting the try TWO requirement.), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. Systemic-onset JIA, approve for patients who have tried one other systemic agent for SJIA (eg, a corticosteroid [oral, IV], a conventional synthetic DMARD [eg, MTX, leflunomide, sulfasalazine], Kineret (anakinra), or Ilaris (canakinumab for SC injection), or a 1-month trial of a nonsteroidal anti-inflammatory drug [NSAID]). Giant cell arteritis, initial-approve if the patient has tried one

<b>PA Criteria</b>	<b>Criteria Details</b>
	systemic corticosteroid. Cont tx, RA/PJIA/SJIA/GCA - approve if the pt had a response as determined by the prescriber. Cytokine release syndrome associated with chimeric antigen receptor (CAR) T-Cell therapy-approve. Please Note: preferred adalimumab products include Humira (NDCs starting with -00074), Cyltezo, Yuflyma.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ACTEMRA SQ

## Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	Interstitial lung disease-18 years and older (initial and continuation)
<b>Prescriber Restrictions</b>	RA/GCA/PJIA/SJIA - Prescribed by or in consultation with a rheumatologist (initial therapy only). Lung disease-presc/consult-pulmonologist or rheum (initial and cont)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	RA initial - approve if the patient meets one of the following (A or B): patient has tried TWO of the following drugs in the past: an adalimumab product, Enbrel, Orencia, Rinvoq or Xeljanz/XR (Note: if the patient does not meet this requirement, previous trial(s) with the following drugs will be counted towards meeting the try TWO requirement: Cimzia, infliximab, golimumab SC/IV), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. PJIA initial, approve if the patient meets one of the following (A or B): patient has tried TWO of the following: Enbrel, Orencia, Rinvoq, Xeljanz, or an adalimumab product (Note: if the patient does not meet this requirement, previous trial with the drug infliximab will be counted towards meeting the try TWO requirement), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. Cont tx, RA/PJIA - approve if the pt had a response as determined by the prescriber. Interstitial lung disease associated with systemic sclerosis initial-approve if the patient has elevated acute phase reactants AND the diagnosis is confirmed by high-resolution computed tomography. Interstitial lung disease assoc with systemic sclerosis, Cont tx-approve if the patient had adequate efficacy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# ACTIMMUNE

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## Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Simultaneous administration of requested medication with other heterologous serum protein or immunological preparations (e.g., vaccines)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Chronic Granulomatous Disease (CGD)-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)- 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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ADALIMUMAB OTHER

## Products Affected

- CYLTEZO(CF) PEN
- CYLTEZO(CF) PEN CROHN'S-UC-HS
- CYLTEZO(CF) PEN PSORIASIS-UV
- CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.4 ML, 40 MG/0.8 ML
- YUFLYMA(CF) AI CROHN'S-UC-HS
- YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML
- YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	CD, 6 or older (initial). UC, 5 or older (initial). PP-18 years and older (initial)
<b>Prescriber Restrictions</b>	Init tx only-RA/JIA/JRA/Ankylosing spondylitis, prescr/consult w/rheum. PsA, prescr/consult w/rheum or derm. PP, prescr/consult w/derm. UC/ CD, prescr/consult w/gastro. HS, presc/consult w/derm. UV, prescr/consult w/ophthalmologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. Plaque psoriasis (PP) initial. approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>psoriasis are not required to step back and try a traditional agent first) OR  2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ileocolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). cont tx - must respond to tx as determined by prescriber.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ADBRY

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## Products Affected

- ADBRY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with another monoclonal antibody (i.e Dupixent, Cinqair, Fasenra, Nucala, Tezspire, or Xolair)
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Dermatologist, allergist, or immunologist
<b>Coverage Duration</b>	Init-4mo, Cont-1 yr
<b>Other Criteria</b>	Initial-Approve if members meets both A and B criteria: A-member has used at least 1 med, med-high, high, and/or super-high-potency prescription topical corticosteroid OR atopic dermatitis is affecting ONLY face, eyes/lids, skin folds, and/or genitalia AND member tried tacrolimus ointment B-member had inadequate response with previous treatments.Cont-pt responded to Adbry.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ADEMPAS

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## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AG EPCLUSA

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## Products Affected

- SOFOSBUVIR-VELPATASVIR

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

# AG HARVONI

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## Products Affected

- LEDIPASVIR-SOFOSBUVIR

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

# AIMOVIG

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## Products Affected

- AIMOVIG AUTOINJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination therapy with Ajovy, Vyepti or Emgality
<b>Required Medical Information</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapy(e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AKEEGA

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## Products Affected

- AKEEGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Prostate cancer- Approve if the patient meets the following (A, B, C, and D): A) Patient has metastatic castration-resistant prostate cancer, AND B) Patient has a BReast CAncer (BRCA) mutation, AND C) The medication is used in combination with prednisone, AND D) Patient meets one of the following (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR ii. Patient has had a bilateral orchiectomy
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ALDURAZYME

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## Products Affected

- ALDURAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient alpha-L-iduronidase activity in leukocytes, fibroblasts, plasma, or serum OR has a molecular genetic test demonstrating alpha-L-iduronidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ALECENSA

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## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC-Approve if the member meets the following A or B: A) Member must have ALK-positive metastatic NSCLC as detected by an FDA approved test OR B) Member will be using medication as adjuvant treatment following tumor resection of ALK-positive NSCLC (tumors greater than or equal to 4 cm or node positive) as detected by an FDA approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ALPHA 1 PROTEINASE INHIBITORS

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## Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)-approve if the patient has a baseline (pretreatment) AAT serum concentration of less than 80 mg/dL or 11 micromol/L.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ALUNBRIG

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	ALK status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ALVAIZ

## Products Affected

- ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Myelodysplastic Syndrome (MDS)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP, Aplastic Anemia-Hematologist or oncologist. Hepatitis C- Gastroenterologist, hematologist, hepatologist, or infectious disease specialist.
<b>Coverage Duration</b>	All indications-Initial-6 months Continuation-12 months
<b>Other Criteria</b>	Initial-Refractory Severe Aplastic Anemia (SAA)-Approve if member has diagnosis of SAA as evidenced by TWO of the following: Absolute neutrophil count (ANC) less than $0.5 \times 10^9/L$ , Platelet count is less than $20 \times 10^9/L$ , Reticulocyte count less than 1% corrected or less than 60,000/microL. Must have documentation confirming platelet levels are less than $50 \times 10^9/L$ . Must have a trial with an inadequate response or significant side effect to immunosuppressive therapy (e.g. cyclosporine, antithymocyte, cyclophosphamide). Chronic Hepatitis C Infection-Associated Thrombocytopenia-Approve if member has diagnosis. Must have documentation confirming platelet levels are less than $75 \times 10^9/L$ . Provider attests requested medication will be used to achieve the target platelet count necessary to initiate antiviral therapy and to avoid reductions in concomitant interferon-based therapy. Chronic Immune Thrombocytopenia (ITP)-Approve if member has diagnosis of ITP. Must have an insufficient response to corticosteroids (i.e. 0.5-2.0 mg/kg prednisone per day), immunoglobulins (IVIG), or splenectomy. Provider must attest the degree of thrombocytopenia and clinical condition increases the risk for bleeding. Reauthorization-Chronic Hepatitis C Infection-Associated Thrombocytopenia-Approve if member continues to receive interferon-based therapy. All Other Indications (including Chronic

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>Hepatitis C Infection-Associated Thrombocytopenia)-Approve if platelet count meets one of the following: less than 50 x 10<sup>9</sup>/L, greater than or equal to 50 x 10<sup>9</sup>/L to 200 x 10<sup>9</sup>/L, greater than or equal to 200 x 10<sup>9</sup>/L to less than or equal to 400 x 10<sup>9</sup>/L with an adjustment to reduce daily dose. Provider must attest to regularly monitoring liver function and hematology laboratory tests. Provider attests member is not experiencing any signs or symptoms of hepatic injury or thromboembolism. Provider attests requested medication will not be used in combination with another thrombopoietin receptor agonist or with Tavalisse (fostamatinib).</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ANTIDEPRESSANTS

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## Products Affected

- AUVELITY
- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR
- *fluvoxamine oral capsule,extended release 24hr*
- TRINTELLIX

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 approval - Approve if member has had a trial and failure with either two preferred SSRIs or one preferred SSRI AND venlafaxine ER Continuation of therapy - Approve if member has positive response to therapy
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

## ANTIFUNGALS (IV)

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### Products Affected

- *fluconazole in nacl (iso-osm)*
- *voriconazole intravenous*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ARCALYST

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## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent biologic therapy
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Initial tx CAPS/Pericarditis-Greater than or equal to 12 years of age.
<b>Prescriber Restrictions</b>	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
<b>Coverage Duration</b>	CAPS-3 mos initial, 1 yr cont. DIRA-6 mos initial, 1 yr cont. Pericard-3 mos initial, 1 yr cont
<b>Other Criteria</b>	CAPS renewal - approve if the patient has had a response as determined by the prescriber. DIRA initial-approve if the patient weighs at least 10 kg, genetic test confirms a mutation in the IL1RN gene and the patient has demonstrated a clinical benefit with anakinra subcutaneous injection. DIRA cont-approve if the patient has responded to therapy. Pericarditis initial-approve if the patient has recurrent pericarditis AND for the current episode, the patient is receiving standard treatment or standard treatment is contraindicated. Continuation-approve if the patient has had a clinical response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ARIKAYCE

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medication history of a multidrug regimen which includes a macrolide antibiotic (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin)
<b>Age Restrictions</b>	MAC-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	MAC initial-Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections. Cystic fibrosis-prescribed by or in consultation with a pulmonologist or physician who specializes in the treatment of cystic fibrosis
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	MAC Lung disease, initial-approve if the patient has a positive sputum culture for mycobacterium avium complex and the culture was collected within the past 3 months and was collected after the patient has completed a background multidrug regimen, the Mycobacterium avium complex isolate is susceptible to amikacin with a minimum inhibitor concentration (MIC) of less than or equal to 64 microgram/mL AND Arikayce 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). MAC Lung Disease, continuation-approve if Arikayce will be used in conjunction with a background multidrug regimen AND i. Patient meets ONE of the following criteria (a or b):a)patient has not achieved negative sputum cultures for Mycobacterium avium complex OR b) patient has achieved negative sputum cultures for Mycobacterium avium complex for less than 12 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# ATYPICAL ANTIPSYCHOTICS

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## Products Affected

- CAPLYTA
- FANAPT ORAL TABLET
- FANAPT ORAL TABLETS,DOSE PACK
- LYBALVI
- REXULTI ORAL TABLET
- VRAYLAR ORAL CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Trial and failure, contraindication, or intolerance to TWO of the following generic formulary atypical antipsychotic agents: aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AUGTYRO

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## Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Non-Small Cell Lung Cancer-approve if the patient has locally advanced or metastatic disease, patient has ROS1-positive non-small cell lung cancer and the mutation was detected by an approved test. Solid Tumors-approve if the member has solid tumors meeting all the following a, b, and c: a) has a neurotropic tyrosine receptor kinase (NTRK) gene fusion, b) are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity, and c) have progressed following treatment or have no satisfactory alternative therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AUSTEDO

## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG, 6 MG (14)-12 MG (14)-24 MG (14)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Tardive Dyskinesia (TD) - Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease - Prescribed by or after consultation with a neurologist.
<b>Coverage Duration</b>	TD: Initial - 3 months. Reauth - 12 months. Chorea associated with Huntington's disease: 1 year.
<b>Other Criteria</b>	Tardive Dyskinesia (TD) (initial): Member must have diagnosis of TD with chart note documentation of one of the following: a) patient has persistent symptoms of TD despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. TD (reauth): Documentation of positive clinical response to therapy. Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AVONEX

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## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	Relapsing forms of multiple sclerosis (MS)-Approve
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# AYVAKIT

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## Products Affected

- AYVAKIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	GIST-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation or if the patient has tried two of the following: Gleevec (imatinib), Sutent (sunitinib), Sprycel (dasatinib), Stivarga (regorafenib) or Qinlock (ripretinib). Systemic mastocytosis- Approve if the patient has a platelet count greater than or equal to 50,000/mcL and patient has either indolent systemic mastocytosis or one of the following subtypes of advanced systemic mastocytosis-aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm or mast cell leukemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BALVERSA

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies, test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Urothelial Carcinoma - Approve is the member meets A, B, and C: A) Member must have locally advanced or metastatic disease AND B) Member has susceptible fibroblast growth factor receptor 3 (FGFR3) genetic alterations AND C) Member disease has progressed on or after at least one line of prior systemic therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BENLYSTA

## Products Affected

- BENLYSTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent Use with Other Biologics or Lupkynis
<b>Required Medical Information</b>	Diagnosis, medications that will be used in combination, autoantibody status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
<b>Coverage Duration</b>	SLE-Initial-4 months, cont-1 year. Lupus Nephritis-6 mo initial, 1 year cont
<b>Other Criteria</b>	Lupus Nephritis Initial-approve if the patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]. Cont-approve if the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA] AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# BESREMI

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## Products Affected

- BESREMI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other interferon products
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BETASERON/EXTAVIA

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## Products Affected

- BETASERON SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	Relapsing forms of multiple sclerosis (MS)-Approve
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BEXAROTENE (ORAL)

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## Products Affected

- *bexarotene oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BOSENTAN/AMBRISENTAN

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## Products Affected

- *ambrisentan*
- *bosentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BOSULIF

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## Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. For CML, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, patient must have Ph-positive CML
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BOTOX

## Products Affected

- BOTOX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the peri-orbital region)
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Migraine headache prevention-prescribed by, or after consultation with, a neurologist or HA specialist.
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	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)
<b>Part B Prerequisite</b>	No

# BRAFTOVI

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## Products Affected

- BRAFTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, BRAF V600 status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation. Colon or Rectal cancer- approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer. NSCLC- approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Mektovi (binimetinib tablets).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# BRIVIACT

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## Products Affected

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial-Approve if member has a diagnosis of partial-onset seizures AND an inadequate response or intolerance to two generic antiepileptic drugs (i.e. levetiracetam, topiramate, lamotrigine) Reauth-Approve if member has been established on medication
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BRUKINSA

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## Products Affected

- BRUKINSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Mantle Cell Lymphoma-Approve if the patient has tried at least one prior therapy. Marginal zone lymphoma-Approve if the patient has tried at least one anti-CD20 based regimen. Waldenstrom macroglobulinemia-Approve. Chronic Lymphocytic Leukemia (CLL)/Small lymphocytic lymphoma (SLL)-Approve. Relapsed or Refractory Follicular Lymphoma (FL)- Approve if patient has tried at least two or more systemic regimens AND pt will be using in combination with obinutuzumab.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# BYLVAY

## Products Affected

- BYLVAY ORAL CAPSULE 1,200 MCG, 400 MCG
- BYLVAY ORAL PELLETT 200 MCG, 600 MCG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	PFIC Type 2 with specific ABCB11 variant resulting in non-functional or complete absence of bile salt export pump (BSEP) protein OR patients with prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Hepatologist or gastroenterologist
<b>Coverage Duration</b>	Initial-6 months Reauth-12 months
<b>Other Criteria</b>	Initial-Alagille Syndrome-Approve if member has a confirmed diagnosis of cholestatic pruritis associated with Alagille Syndrome. Must provide lab results of genetic testing confirming a JAG1 or NOTCH2 deletion or mutation and serum bile acid concentration above the upper limit of normal. Must have trial with an inadequate response or significant side effect or contraindication to at least ONE medications for ALGS-associated pruritis (e.g. ursodeoxycholic acid (Ursodiol), rifampin) AND maralixibat (Livmarli). Must provide baseline Itch Reported Outcome (ItchRO) score and chart documentation describing the pruritis with the associated symptoms (i.e. sleep disturbances, difficulty concentrating during the day). Must provide current weight. Must request dose that falls within the recommended dosing guidelines from the manufacturer. Reauthorization-ALGS-Approve if chart note documentation from the provider supports the condition has improved while on therapy (i.e. reduction in serum bile acids from baseline, decrease in baseline pruritis score) and the member continues to benefit from therapy. Must provide current weight. Must request dose that falls within the recommended dosing guidelines from the manufacturer. Progressive Familial Intrahepatic Cholestasis (PFIC)- Approve if member has a diagnosis of PFIC. Must provide weight and

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>request dose that falls within the recommended dosing guidelines from the manufacturer. Must provide results of genetic testing demonstrating a gene mutation affiliated with PFIC (e.g. ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, MYO5B). Must submit labs documenting the total serum bile salt concentration above the upper limit of normal. Must provide baseline Itch Reported Outcome (ItchRO) score. Must have a documented trial with an inadequate response or significant side effect or documented contraindication to at least TWO medications for PFIC-associated pruritis (e.g. rifampicin, cholestyramine, ursodeoxycholic acid (Ursodiol). Reauthorization-PFIC-Approve if chart note documentation from the provider supports the condition has improved while on therapy (i.e. reduction in serum bile acids from baseline, decrease in baseline pruritis score) and the member continues to benefit from therapy. Must provide current weight. Must request dose that falls within the recommended dosing guidelines from the manufacturer.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# C1 ESTERASE INHIBITORS

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## Products Affected

- CINRYZE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II], Prophylaxis, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50 percent of normal) at baseline and lower than normal serum C4 levels at baseline. Patient is currently taking Cinryze for prophylaxis - approve if the patient meets the following criteria (i and ii): i) patient has a diagnosis of HAE type I or II, and ii) according to the prescriber, the patient has had a favorable clinical response since initiating Cinryze as prophylactic therapy compared with baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CABLIVI

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## Products Affected

- CABLIVI INJECTION KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, concurrent medications
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	Approve for 12 months
<b>Other Criteria</b>	aTTP-approve if the requested medication was initiated in the inpatient setting in combination with plasma exchange therapy AND patient is currently receiving at least one immunosuppressive therapy AND if the patient has previously received Cablivi, he/she has not had more than two recurrences of aTTP while on Cablivi.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CABOMETYX

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## Products Affected

- CABOMETYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, histology
<b>Age Restrictions</b>	Thyroid carcinoma-12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renal Cell Carcinoma-Approve if the patient has relapsed or stage IV disease. Hepatocellular Carcinoma-approve if the patient has been previously treated with at least one other systemic therapy (e.g., Nexavar, Lenvima). Thyroid carcinoma-approve if the patient has differentiated thyroid carcinoma, patient is refractory to radioactive iodine therapy and the patient has tried a vascular endothelial growth factor receptor (VEGFR)-targeted therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CALQUENCE

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## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

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	Mantle Cell Lymphoma (MCL) - approve if the patient has tried at least one prior therapy. Small lymphoplasmacytic lymphoma (SLL)-approve. Chronic lymphocytic leukemia (CLL)-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No



# CAMZYOS

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## Products Affected

- CAMZYOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant treatment with disopyramine or ranolazine. Concomitant treatment with a beta-blocker and calcium channel blocker taken together. Concomitant treatment with moderate to strong CYP2C19 inhibitors/inducers or strong CYP3A4 inhibitors/inducers.
<b>Required Medical Information</b>	Diagnosis, NYHA Classification, Echocardiogram or CMR
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Symptomatic obstructive hypertrophic cardiomyopathy (HCM) - diagnosis confirmed through echocardiogram or cardiovascular magnetic resonance imaging. Patient must meet ALL of the following criteria: 1) New York Heart Association (NYHA) class II-III symptoms. 2) Left Ventricular ejection Fraction (LVEF) equals 55% or greater. 3) Left ventricular outflow track (LVOT) gradient of 50mmHg or higher. 4) Patient has a trial and failure of two of the following medications or medication classes: A) Beta-blocker, B) Calcium channel blocker, C) disopyramide
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CAPRELSA

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

# CARBAGLU

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## Products Affected

- *carglumic acid*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	NAGS-Pt meets criteria no genetic test - 3mo. Pt had genetic test - 12mo, other-approve 7 days
<b>Other Criteria</b>	N-Acetylglutamate synthase deficiency with hyperammonemia-Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency or if the patient has hyperammonemia. Propionic Acidemia or Methylmalonic Acidemia with Hyperammonemia, Acute Treatment-approve if the patient's plasma ammonia level is greater then or equal to 50 micromol/L and the requested medication will be used in conjunction with other ammonia-lowering therapies.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CAYSTON

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## Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist, infectious disease specialist, or a physician who specializes in the treatment of cystic fibrosis.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has <i>Pseudomonas aeruginosa</i> in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CENOBAMATE

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Familial Short QT Syndrome
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial-Approve if member has a diagnosis of partial-onset seizures AND an inadequate response or intolerance to two generic antiepileptic drugs (i.e. levetiracetam, topiramate, lamotrigine) Reauth-Approve if member has been established on medication
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CEPROTIN

## Products Affected

- CEPROTIN (BLUE BAR)
- CEPROTIN (GREEN BAR)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Protein C Deficiency, Severe-approve if the patient meets the following criteria A, B and C: A) The diagnosis of protein C deficiency is confirmed by at least one of the following (i, ii, or iii): i. Plasma protein C activity below the lower limit of normal based on the age-specific reference range for the reporting laboratory OR ii. Plasma protein C antigen below the lower limit of normal based on the age-specific reference range for the reporting laboratory OR iii. Genetic testing demonstrating biallelic mutations in the PROC gene AND B) Acquired causes of protein C deficiency have been excluded AND C) Patient has a current or prior history of symptoms associated with severe protein C deficiency (e.g., purpura fulminans, thromboembolism).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CHEMET

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## Products Affected

- CHEMET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Blood lead level
<b>Age Restrictions</b>	Approve in patients between the age of 12 months and 18 years
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
<b>Coverage Duration</b>	Approve for 2 months
<b>Other Criteria</b>	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CHOLBAM

## Products Affected

- CHOLBAM ORAL CAPSULE 250 MG,  
50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination Therapy with Chenodal
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
<b>Coverage Duration</b>	3 mos initial, 12 mos cont
<b>Other Criteria</b>	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis or molecular genetic testing consistent with the diagnosis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS or molecular genetic testing consistent with the diagnosis AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improvement in steatorrhea) AND does not have complete biliary obstruction.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# CIMZIA

## Products Affected

- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT
- CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	18 years and older for CD and PP (initial therapy), PJIA-2 years and older
<b>Prescriber Restrictions</b>	All dx initial therapy only. RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist. PsA prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. nr-axSpA/PJIA-prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial-Ankylosing Spondylitis (AS)-Approve if the patient has tried TWO of the following: an adalimumab product, Enbrel, Xeljanz/XR. Initial-Psoriatic Arthritis (PsA)-Approve if the patient has tried TWO of the following: Enbrel, an adalimumab product, Stelara, Otezla, Orencia, Rinvoq, Skyrizi or Xeljanz/XR. PJIA/RA (Initial)-Approve if the patient has tried two of the following: Enbrel, an adalimumab product, Orencia, Rinvoq or Xeljanz/XR. Initial-Crohn's Disease (CD)-Approve if patient has previously tried an adalimumab product. Initial-Plaque Psoriasis (PP)-Approve if the patient has tried TWO of the following: Enbrel, an adalimumab product, Skyrizi, Stelara SC, Otezla. Reauthorization-AS/PsA/RA/CD/PP-Approve if the patient had a response as determined by the prescriber. Initial-Non-radiographic axial spondylitis (nr-axSpA)-Approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroilitis reported on MRI. Reauthorization-nr-axSpA-Approve if the patient has had a response as determined by the prescriber.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CLOBAZAM

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# COBENFY

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## Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Urinary or gastric retention, untreated narrow-angle glaucoma, moderate or severe hepatic impairment
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial: Member must have a diagnosis of schizophrenia and chart note documentation showing two or more of the following symptoms: 1) delusions 2) hallucinations 3) disorganized speech 4) grossly disorganized or catatonic behavior 5) negative symptoms (i.e reduced emotion expression, lack of motivation, social withdrawal). Member must have an inadequate response or significant side effect/toxicity or have a contraindication to cariprazine (Vraylar) AND brexpiprazole (Rexulti). Reauthorization Criteria: Approve if the member has responded positively to therapy as determined by the prescribing physician
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# COMETRIQ

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis.
<b>Age Restrictions</b>	MTC-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	MTC - approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# COPIKTRA

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## Products Affected

- COPIKTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For all covered diagnoses, approve if the patient has tried Imbruvica prior to approval of Copiktra.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CORLANOR

## Products Affected

- CORLANOR ORAL SOLUTION
- IVABRADINE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic heart failure (CHF) (initial): Diagnosis of CHF. Patient has NYHA Class II, III, or IV symptoms. Patient has a left ventricular ejection fraction less than or equal to 35%. Patient is in sinus rhythm. Patient has a resting heart rate of greater than or equal to 70 beats per minute. One of the following: patient is on a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate extended release) at a maximally tolerated dose, or patient has a contraindication or intolerance to beta-blocker therapy. Patient has been hospitalized for worsening HF in the previous 12 months. Trial and failure, contraindication, or intolerance to maximally tolerated doses of an ACE inhibitor (e.g., captopril, enalapril, lisinopril) or ARB (e.g., candesartan, losartan, valsartan). Dilated Cardiomyopathy (DCM) (initial): Diagnosis of heart failure due to DCM. Patient has NYHA Class II, III, or IV symptoms. Patient is in sinus rhythm. Patient has an elevated heart rate. Trial and failure, contraindication or intolerance to one of the following: 1) Beta blocker (e.g., bisoprolol, metoprolol succinate extended release), 2) Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), or 3) Diuretic Agent (e.g., spironolactone, furosemide).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CHF, DCM (initial): Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	CHF, DCM (initial, reauth): 12 months
<b>Other Criteria</b>	CHF, DCM (reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CORTROPHIN GEL

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## Products Affected

- *cortrophin gel*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS: neurologist. RA, Psoriatic Arthritis, Ankylosing Spondylitis rheumatologist. Lupus, Dermatomyositis, Severe Psoriasis, Atopic Dermatitis: dermatologist or rheumatologist. Eye dx: ophthalmologist. Nephrotic syndrome: nephrologist. Acute Gouty Arthritis: rheumatologist, nephrologist. All other dx: no prescriber restrictions.
<b>Coverage Duration</b>	30 days.
<b>Other Criteria</b>	Initial-Multiple sclerosis (MS): must be experiencing acute exacerbation and have trial, contraindication, or intolerance of 2 IV steroids w/ inadequate response or significant side effects/toxicity. Provide rationale why corticosteroids are not expected to produce the same clinical results as expected with Purified Cortrophin Gel. For severe erythema multiforme (Stevens-Johnsons Syndrome), serum sickness, severe psoriasis, atopic dermatitis, severe acute or chronic allergic or inflammatory processes involving eye and its adnexa (e.g., allergic conjunctivitis, keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroditis, optic neuritis, chorioretinitis, anterior segment inflammation), symptomatic sarcoidosis: must have trial, contraindication, or intolerance of 2 IV steroids w/ inadequate response or significant side effects/toxicity. Provide rationale why corticosteroids are not expected to produce the same clinical results as expected with Purified Cortrophin Gel. Initial-RA (including Juvenile RA), psoriatic arthritis, ankylosing spondylitis, acute gouty arthritis: must be using as adjunctive therapy for short-term administration and have trial, contraindication, or intolerance of 2 IV steroids w/ inadequate response or significant side effects/toxicity. Provide rationale why corticosteroids are not expected to produce the same clinical results as expected with Purified



<b>PA Criteria</b>	<b>Criteria Details</b>
	Cortrophin Gel. Initial-Systemic Lupus Erythematosis (SLE), dermatomyositis (polymyositis): may be used during exacerbation or as maintenance therapy and must have trial, contraindication, or intolerance of 2 IV steroids with inadequate response or significant side effects/toxicity. Provide rationale why corticosteroids are not expected to produce the same clinical results as expected with Purified Cortrophin Gel. Reauthorization (all diagnoses): must have documentation from prescriber describing initial response to therapy and need for continuation or retreatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	Yes

# COSENTYX

## 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
<b>Exclusion Criteria</b>	Concomitant use with TNF-blocking or other biologic agent
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	HS: 18 years and older
<b>Prescriber Restrictions</b>	Plaque psoriasis and Hidradentitis Supprativa (HS) - Prescribed by or in consultation with a dermatologist (initial therapy). PsA - prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). Ankylosing spondylitis, nonradiographic axial spondyloarthritis, or enthesitis-related arthritis (ERA) - prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For ankylosing spondylitis: must have active disease AND must have trial of 2 NSAIDs at target anti-inflammatory dose with inadequate responses or significant side effects/toxicity or have a contraindication. For nonradiographic axial spondyloarthritis: must have at least one documented magnetic resonance imaging (MRI) scan with results showing inflammation OR C-reactive protein (CRP) levels above the upper limit of normal AND must have trial with 2 NSAIDs with an inadeq response or signif side effects/toxicity or have a contraindication to this therapy. For PsA or ERA: must have active disease AND must have trial of 1 conventional systemic therapy (e.g., methotrexate, leflunomide, cyclosporine, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For plaque psoriasis: must have trial of 1 conventional systemic therapy (e.g., methotrexate, acitretin, cyclosporine) with inadequate response or significant side effects/toxicity or have a contraindication OR phototherapy or photochemotherapy with inadequate response or significant side

<b>PA Criteria</b>	<b>Criteria Details</b>
	effects/toxicity or have a contraindication. For Hidradenitis Supprativa (HS): diagnosis for at least 1 year AND lesions on two distinct areas of the body AND one of the following: Hurley Stage II defined as one or more widely separated recurrent abscesses with tract information and scars or Hurley Stage III defined as multiple interconnected tracts and abscesses throughout an entire area AND a trial and failure of 90-day course of oral antibiotics for treatment of HS. For reauth: must have documentation from prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# COTELLIC

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## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma initial - must have BRAF V600 mutation.
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf. Histiocytic neoplasms - Approve if member will be used as a single agent.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CRYSVITA

## Products Affected

- CRYSVITA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Chronic Kidney Disease (CKD), Severe Renal Impairment or End Stage Renal Disease
<b>Required Medical Information</b>	Diagnosis, lab values
<b>Age Restrictions</b>	TIO-2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or nephrologist (initial therapy)
<b>Coverage Duration</b>	XLH-1 year (initial/cont), TIO-initial-6 months, cont-1 year
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CUVRIOR

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## Products Affected

- CUVRIOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Member must have tried and failed penicillamine
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# CYSTEAMINE (OPHTHALMIC)

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## Products Affected

- CYSTARAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



## CYSTEAMINE (ORAL)

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### Products Affected

- CYSTAGON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Cystagon and Procysbi
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DALFAMPRIDINE

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## Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older (initial and continuation therapy)
<b>Prescriber Restrictions</b>	MS. If prescribed by, or in consultation with, a neurologist or MS specialist (initial and continuation).
<b>Coverage Duration</b>	Initial-4months, Continuation-1 year
<b>Other Criteria</b>	Initial-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has impaired ambulation as evaluated by an objective measure (e.g., timed 25 foot walk and multiple sclerosis walking scale-12). Continuation-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DALIRESP

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## Products Affected

- *roflumilast*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DAURISMO

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## Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, medications that will be used in combination, comorbidities
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML - approve if Daurismo will be used in combination with cytarabine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DEFERASIROX

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## Products Affected

- *deferasirox*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum ferritin level
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve if the patient is benefiting from therapy as confirmed by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DEFERIPRONE

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## Products Affected

- DEFERIPRONE ORAL TABLET 1,000 MG
- *deferiprone oral tablet 500 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum ferritin level
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias Initial therapy - approve. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DIABETIC SUPPLIES

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## Products Affected

- *alcohol pads*
- GAUZE PADS 2 X 2
- INSULIN PEN NEEDLE
- INSULIN SYRINGE (DISP) U-100 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- NEEDLES, INSULIN DISP.,SAFETY

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

# DIACOMIT

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-Initial therapy-approve if the patient is concomitantly receiving clobazam or is unable to take clobazam due to adverse events. Dravet Syndrome-Continuation-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# DIFICID

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## Products Affected

- DIFICID ORAL SUSPENSION FOR RECONSTITUTION
- DIFICID ORAL TABLET

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 had a trial and failure of vancomycin 125mg by mouth four times daily for 10 days and member is experiencing another infection following an initial infection episode of c. difficile or symptoms from the intial infection did not improve after initial treatment
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# DIMETHYL FUMARATE

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DOPTELET

## Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, platelet count, date of procedure (Thrombocytopenia with chronic liver disease)
<b>Age Restrictions</b>	18 years and older (for chronic ITP-initial therapy only)
<b>Prescriber Restrictions</b>	Chronic ITP-prescribed by or after consultation with a hematologist (initial therapy)
<b>Coverage Duration</b>	Thrombo w/chronic liver disease-5 days, chronic ITP-initial-3 months, cont-1 year
<b>Other Criteria</b>	Thrombocytopenia with chronic liver disease-Approve if the patient has a current platelet count less than 50 x 10 <sup>9</sup> /L AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy. Chronic ITP initial-approve if the patient has a platelet count less than 30,000 microliters or less than 50,000 microliters and is at an increased risk of bleeding and must have a trial with an inadequate response or significant side effect/toxicity to ONE of the following: corticosteroids or intravenous immunoglobulin (IVIG). Continuation-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DRIZALMA

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. Must have documentation showing that administration via nasogastric tube is required OR documentation of inability to swallow an intact capsule.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Fibromyalgia: must have a trial of gabapentin solution with inadequate response or significant side effects/toxicity or have a contraindication to this therapy. GAD: must have a trial of sertraline concentrate with inadequate response or significant side effects/toxicity or have a contraindication to this therapy. MDD: must have a trial of fluoxetine solution with inadequate response or significant side effects/toxicity or have a contraindication to this therapy
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# DUPIXENT

## 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
<b>Exclusion Criteria</b>	COPD-Concurrent use with Ohtuvayre, Xolair, or another Anti-interleukin (IL) Monoclonal Antibody. All others-Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
<b>Required Medical Information</b>	Diagnosis, prescriber specialty, other medications tried and length of trials. For COPD: (Initial)-Member must have a diagnosis of inadequately controlled, eosinophilic phenotype of COPD with chart note documentation and lab values taken within the previous 6 weeks or prior to starting therapy with the requested medication or another monoclonal antibody showing eosinophils greater than or equal to 300 cells per microL, FEV1/FVC ratio less than 0.7, and FEV1 of greater than or equal to 30 percent but less than or equal to 80 percent post-bronchodilator. Member must currently be treated with triple therapy (LABA/LAMA/ICS) or dual therapy (LAMA/LABA) for at least 3 months AND member has signs or symptoms of chronic bronchitis for at least 3 months in the previous 12 months AND meets (A, B, C, or D): A) member experienced two or more exacerbations requiring treatment with short-acting bronchodilators and oral corticosteroids in the previous year B) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year C) Modified Medical Research Council (mMRC) dyspnea grade is greater than or equal to 2 or D) COPD Assessment Test (CAT) score is greater than or equal to 10. Provider attests member will continue dual or triple therapy while on requested medication. (Reauth)-Member continues to receive requested medication with dual or triple therapy combination AND member has responded positively to therapy as determined by the prescribing physician.
<b>Age Restrictions</b>	AD-6 months and older, asthma-6 years of age and older, Esophagitis-1 year and older, Chronic Rhinosinusitis-12 years and older, COPD/PN-18 years and older
<b>Prescriber Restrictions</b>	Atopic Dermatitis/prurigo nodularis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist,

PA Criteria	Criteria Details
	immunologist or otolaryngologist. Esophagitis-presc/consult-allergist or gastro, COPD-Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	AD-Init-4mo, Cont-1 yr, COPD/asthma/Rhinosinusitis/esophagitis/prurigo nod-init-6 mo, cont 1 yr
<b>Other Criteria</b>	<p>AD,Init-pt 2yrs and older-pt meets a and b:a.used at least 1 med,med-high,high, and/or super-high-potency rx top CS OR AD affecting ONLY face,eyes/lids,skin folds,and/or genitalia and tried tacrolimus oint AND b.Inadeq efficacy was demonstrated w/prev tx.AD,Init-pt between 6 mo and less than 2 yr-pt meets a and b:a.used at least 1 med,med-high,high, and/or super-high-potency rx top CS and b.inadeq efficacy was demonstrated w/prev tx OR AD affecting ONLY face,eyes/lids,skin folds,and/or genitalia.Cont-pt responded to Dupixent.Asthma,init-pt meets (i, ii, and iii):i.Pt meets (a or b):a)blood eosinophil greater than or equal to 150 cells per microliter w/in prev 6 wks or within 6 wks prior to tx with any IL tx or Xolair OR b)has oral CS-dependent asthma, AND ii.received combo tx w/following (a and b): a)ICS AND b)1 add asthma control/maint med(NOTE:exception to the requirement for a trial of 1 add asthma controller/maint med can be made if pt already received anti-IL-5 tx or Xolair used concomitantly w/an ICS AND iii.asthma uncontrolled or was uncontrolled prior to starting anti-IL tx or Xolair defined by 1 (a, b, c, d or e): a)exper 2 or more asthma exacer req tx with systemic CS in prev yr OR b)exper 1 or more asthma exacer requiring hosp or ED visit in prev yr OR c)FEV1 less than 80percent predicted OR d)FEV1/FVC less than 0.80 OR e)asthma worsens w/tapering of oral CS tx.Cont-pt meets (i and ii): i.cont to receive tx with 1 ICS or 1 ICS-containing combo inhaler AND ii.has responded to Dupixent.Chronic rhinosinusitis w/nasal polyposis,init-pt receiving tx with an intranasal CS and experi rhinosinusitis symptoms like nasal obstruction, rhinorrhea, or reduction/loss of smell AND meets 1 (a or b): a)received tx w/syst CS w/in prev 2 yrs or has contraindication to systemic CS tx OR b)prior surgery for nasal polyps. Cont-pt cont to receive tx with an intranasal CS and responded to Dupixent. Eosino esoph, init-weighs greater than or equal to 15 kg, has dx of eosino esophagitis confirmed by endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field, and does not have a secondary cause of eosino esophagitis, and has received at least 8 wks of tx with a Rx strength PPI. Cont-pt received at least 6mo of tx with Dupixent and has experi reduced intraepithelial eosinophil count or decreased dysphagia/pain upon swallowing or reduced frequency/severity of food impaction.Prurigo Nod, init-pt has greater than or equal to 20 nodular lesions and pt has experienced pruritus at least 6 wks, AND pt tried at least 1 high- or super-high-potency Rx topical CS. Cont-pt received at least 6</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	mo of tx with Dupixent and has experi reduced nodular lesion count, decreased pruritis or reduced nodular lesion size.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ELAPRASE

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## Products Affected

- ELAPRASE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has laboratory test demonstrating deficient iduronate-2-sulfatase activity in leukocytes, fibroblasts, serum or plasma OR a molecular genetic test demonstrating iduronate-2-sulfatase gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# EMGALITY

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination therapy with Aimovig, Vyepti or Ajovy
<b>Required Medical Information</b>	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Cluster headache tx-6 months, migraine prevention-1 year
<b>Other Criteria</b>	Migraine headache prevention-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. Episodic cluster headache treatment-approve if the patient has between one headache every other day and eight headaches per day.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ENBREL

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. Psoriatic arthritis, prescribed by or in consultation w/ rheumatologist or dermatologist.Plaque psoriasis (PP), prescribed by or in consult w/ dermatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other systemic therapy for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID), biologic or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice

<b>PA Criteria</b>	<b>Criteria Details</b>
	weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ENDARI

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## Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with Oxbryta or Adakveo
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist or hematologist
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Initial: Diagnosis of sickle cell disease. Must have documentation the member has experienced at least 2 sickle cell-related vaso-occlusive crises within the last 12 months requiring a medical facility visit (e.g., emergency department, infusion center, or hospital). Chart documentation of medical facility visit is required. Must have an adequate trial of at least 90 days on oral hydroxyurea (e.g., hydroxyurea tablet) with an inadequate response or significant side effects/toxicity or have a contraindication to this therapy. Reauth: must have documentation from the prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ENTYVIO

## Products Affected

- ENTYVIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent Use with Other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs) used for an Inflammatory Condition
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	CD/UC - adults (initial therapy)
<b>Prescriber Restrictions</b>	CD/UC initial - Prescribed by or in consultation with a gastroenterologist. (initial therapy)
<b>Coverage Duration</b>	CD/UC - initial 14 weeks, cont 1 year
<b>Other Criteria</b>	CD Initial - the patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated in this patient OR the patient has tried one conventional systemic therapy for Crohn's disease (e.g., azathioprine, 6-mercaptopurine, or methotrexate) OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). Note: an exception to the requirement for a trial of or contraindication to steroids or a trial of one other conventional systemic agent can be made if the patient has already tried a biologic. Cont tx - had a response to Entyvio, as determined by the prescribing physician. UC initial-the patient has had a trial of one systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone). NOTE: A trial of a biologic (e.g., an adalimumab product [e.g., Humira], an infliximab product [e.g., Remicade, Inflectra, or Renflexis], or Simponi [golimumab for SC injection]) also counts as a trial of one systemic agent for UC. Cont tx - had a response to Entyvio (for example, decreased stool frequency or rectal bleeding), as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# EPIDIOLEX

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## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or if the patient has tried or is concomitantly receiving one of Diacomit or clobazam or Fintepla. Lennox Gastaut Syndrome-approve if the patient has tried or is concomitantly receiving at least two other antiepileptics drugs. Tuberous Sclerosis Complex-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Continuation of therapy-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# EPOETIN ALFA

## Products Affected

- PROCRIT
- RETACRIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Chemo-6m,Transfus-1m, CKD-1yr, all others-1 yr
<b>Other Criteria</b>	Anemia in patients with chronic renal failure on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundled payment benefit).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ERGOT ALKALOIDS

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## Products Affected

- *dihydroergotamine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial approval - Approve if member has diagnosis of acute migraine. Must have trials of two different formulary triptans with inadequate responses or significant side effects/toxicity unless contraindicated. Continuation of therapy - Documentation from prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ERIVEDGE

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## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	BCC (La or Met) - must not have had disease progression while on Odomzo.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy. Basal cell carcinoma, metastatic-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ERLEADA

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## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ERLOTINIB

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Advanced or Metastatic NSCLC, approve if the patient has sensitizing EGFR mutation positive non-small cell lung cancer as detected by an approved test. Note-Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. Pancreatic cancer-approve if the medication is used in combination with gemcitabine and if the patient has locally advanced, metastatic or recurrent disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ESBRIET

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## Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 801 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# EVEROLIMUS

## Products Affected

- *everolimus (antineoplastic) oral tablet*
- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast Cancer-HER2 status, hormone receptor (HR) status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Breast Cancer-Approve if member is a postmenopausal woman with advanced hormone receptor-positive (HR+), HER2-negative breast cancer AND medication will be used in combination with exemestane after failure of treatment with letrozole or anastrozole. PNET and NET-Approve if member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR diagnosis of progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin that are unresectable, locally advanced or metastatic. RCC-Approve if member has a diagnosis of advanced renal cell carcinoma after failure of treatment with sunitinib or sorafenib. TSC-Approve if member has diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC) not requiring immediate surgery. TSC Associated SEGA-approve if pt requires therapeutic intervention but cannot be curatively resected. TSC-associated partial-onset seizures-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# EVRYSDI

## Products Affected

- EVRYSDI ORAL RECON SOLN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on both of the following: 1) Invasive ventilation or tracheostomy and 2) Use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam (HINE) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Upper Limb Module (ULM) Test (Non ambulatory), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Motor Function Measure 32 (MFM-32) Scale, Bayley Scales of Infant and Toddler Development, Third Edition (BSID-III) [item 22], Revised Upper Limb Module (RULM) test, or World Health Organization motor milestone scale. Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA
<b>Coverage Duration</b>	Initial, Reauth: 12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	SMA (Reauth): Documentation of positive clinical response to therapy. Patient (Pt) continues to not be dependent on the following: use of non-invasive ventilation beyond use for naps and nighttime sleep. Pt is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) pt has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) pt has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# FABHALTA

## Products Affected

- FABHALTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other complement inhibitor therapies (i.e empaveli, soliris, ultomiris), unresolved serious infection caused by encapsulated bacteria
<b>Required Medical Information</b>	Diagnosis and diagnostics listed in Other Criteria
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>PNH (Initial)-Approve if the member meets the following A and B: A) Member has a diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed by glycosylphosphatidylinositol (GPI) protein deficiencies (e.g. CD55, CD59) via flow cytometry AND B) Member must have meningococcal vaccine at least two weeks prior to initiation of the requested medication. PNH (Reauth)-Member has experienced a positive response to treatment with the requested medication as determined by the provider. IgAN (Initial-Member must meet all the following criteria A, B, C, and D: A) Member must have a diagnosis of biopsy-proven, primary IgAN and is at risk of rapid disease progression. B) Diagnosis of IgAN is confirmed by total urine protein greater than or equal to 1 g/day AND urine protein-to-creatinine ratio is greater than or equal to 1.5 g/g. C) Attestation the member will avoid concomitant therapy with strong CYP2C8 inducers (e.g rifampin) and inhibitors (e.g. gemfibrozil) D) Must have a trial of at least 90 days with an inadequate response (defined as proteinuria greater than 1g/day OR UPCR greater than or equal to 1.5 g/g) OR member must have significant side effect/toxicity or have a contraindication to Filispari. IgAN (Reauth)-Member must have reduction in proteinuria from baseline after initial approval AND member has not experienced any treatment-restricting adverse effects (e.g., serious and life-threatening infections).</p>
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FABRAZYME

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## Products Affected

- FABRAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient alpha-galactosidase A activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating mutations in the galactosidase alpha gene.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FASENRA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	EGPA-18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 12 months continuation.
<b>Other Criteria</b>	<p>Initial - Must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND meet both of the following criteria: 1) Patient has received combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, or theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following: a) patient experienced one or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted (90 percent for adolescents), OR d) Patient has an FEV1/FVC less than 0.80 (0.90 for adolescents), OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy.</p> <p>NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS. Continuation-The member has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid. EGPA initial-approve if pt has active, non-severe disease, has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to tx w/any anti-IL-5 tx. Cont-pt responded to tx as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FILSPARI

## Products Affected

- FILSPARI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of any of the following: Renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists (ERAs), aliskiren, Strong CYP3A inhibitors, Strong CYP3A inducers, Histamine H2 receptor antagonists, Proton pump inhibitors, Sensitive substrates of P-glycoprotein (P-gp), breast cancer resistance protein (BCRP), Tarpeyo
<b>Required Medical Information</b>	Diagnosis, lab tests as noted in other criteria
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist
<b>Coverage Duration</b>	Initial: 6 months, Re-authorization: 12 months
<b>Other Criteria</b>	Initial approval-Member must meet all of the following: 1) Diagnosis of biopsy-proven, primary immunoglobulin A nephropathy (IgAN) and is at risk of rapid disease progression, 2) Diagnosis of IgAN is confirmed by all of the following: Total urine protein greater than or equal to 1 g/day, Urine protein-to-creatinine ratio is greater than or equal to 1.5 g/g, eGFR greater than or equal to 30 mL/min/1.73m <sup>2</sup> , 3) Confirmation member does not have ALT/AST greater than 3 times the upper limit of normal, 4)Confirmation Members renal function and potassium levels will be monitored frequently. Re-authorization approval-Member must meet ALL of the following: 1) Member must have reduction in proteinuria from baseline after initial approval, 2) Member has not experienced any treatment-restricting adverse effects (e.g., hepatotoxicity, acute kidney injury, severe hypotension, hyperkalemia).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FINGOLIMOD

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## Products Affected

- *fingolimod*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of fingolimod with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FINTEPLA

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## Products Affected

- FINTEPLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-Initial therapy-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or patient has tried or is concomitantly receiving Epidiolex, Clobazam or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy. Lennox-Gastaut Syndrome, initial-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Lennox-Gastaut Syndrome, continuation-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# FIRDAPSE

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## Products Affected

- FIRDAPSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizures (initial therapy)
<b>Required Medical Information</b>	Diagnosis, seizure history, lab and test results
<b>Age Restrictions</b>	6 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
<b>Coverage Duration</b>	Initial-3 months, Cont-1 year
<b>Other Criteria</b>	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FOTIVDA

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## Products Affected

- FOTIVDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other therapies
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Renal Cell Carcinoma (RCC)-approve if the patient has relapsed or Stage IV disease and has tried at least two other systemic regimens. Note: Examples of systemic regimens for renal cell carcinoma include axitinib tablets, axitinib + pembrolizumab injection, cabozantinib tablets, cabozantinib + nivolumab injection, sunitinib malate capsules, pazopanib tablets, sorafenib tablets, and lenvatinib capsules + everolimus.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# FRUZAQLA

## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Colon and rectal cancer-Approve if the patient meets the following (A and B): A.Patient has metastatic disease, AND B.Patient has previously been treated with the following (i, ii, and iii): i.Fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, Note: Examples of fluoropyrimidine agents include 5-fluorouracil (5-FU) and capecitabine. AND ii.An anti-vascular endothelial growth factor (VEGF) agent, Note: Examples of anti-VEGF agents include bevacizumab. AND iii. If the tumor is RAS wild-type (KRAS wild-type and NRAS wild-type) [that is, the tumor or metastases are KRAS and NRAS mutation negative], the patient meets ONE of the following (a or b): a.According to the prescriber, anti-epidermal growth factor receptor (EGFR) therapy is NOT medically appropriate, OR b. The patient has received an anti-EGFR therapy. Note: Examples of anti-EGFR therapy includes Erbitux (cetuximab intravenous infusion) and Vectibix (panitumumab intravenous infusion).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# GALAFOLD

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## Products Affected

- GALAFOLD

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Fabry Disease (FD) (initial): Diagnosis of FD. Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data. FD (initial, reauthorization): Will not be used in combination with Fabrazyme (agalsidase beta).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	FD (initial, reauth): 12 months.
<b>Other Criteria</b>	FD (reauthorization): Documentation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# GATTEX

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## Products Affected

- GATTEX 30-VIAL
- GATTEX ONE-VIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced improvement.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# GAVRETO

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## Products Affected

- GAVRETO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	NSCLC-18 years and older, thyroid cancer-12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC-approve if the patient has metastatic disease and rearranged during transfection (RET) fusion-positive disease detected by an Food and Drug Administration (FDA) approved test. Thyroid cancer - approve if the patient has advanced or metastatic rearranged during transfection (RET) fusion-positive disease, the disease is radioactive iodine-refractory AND the disease requires treatment with systemic therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# GILOTRIF

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## Products Affected

- GILOTRIF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	NSCLC EGFR pos - For the treatment of advanced or metastatic non small cell lung cancer (NSCLC) - approve if the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: examples of sensitizing EGFR mutation-positive NSCLC include the following mutations : exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. NSCLC metastatic squamous cell must have disease progression after treatment with platinum based chemotherapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# GLATIRAMER

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No





# GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prostate cancer-prescr/consult with oncologist or urologist. For the treatment of other cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	uterine leiomyomata approve 3months/all other dx 12 mo
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# GROWTH HORMONES

## Products Affected

- OMNITROPE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def], or prolactin).3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Prader Willi (initial for child/adult and cont tx in adults), SGA (initial) - prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	ISS - 6 mos initial, 12 months cont tx, others 12 mos
<b>Other Criteria</b>	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial -baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy. Cont Tx for PW in child/adolescents and TS - prescriber confirms response to therapy.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# HETLIOZ

## Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-24-patient is totally blind with no perception of light
<b>Age Restrictions</b>	Non-24-18 years or older (initial and continuation), SMS-16 years and older
<b>Prescriber Restrictions</b>	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders (initial and continuation)
<b>Coverage Duration</b>	6 mos initial, 12 mos cont
<b>Other Criteria</b>	Initial-Approve if member is totally blind with no perception of light, dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont-Approve if member is totally blind with no perception of light and pt has achieved adequate results with tasimelteon therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep). Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# HUMIRA

## Products Affected

- HUMIRA PEN
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML
- HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC) 5 or older (initial therapy only), PP-18 or older (initial therapy only)
<b>Prescriber Restrictions</b>	Initial therapy only for all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve Humira (NDCs starting with 00074-) Only when the member meets the following criteria - RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ileocolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IBRANCE

## Products Affected

- IBRANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Breast cancer - Must have a trial of Verzenio or Kisqali prior to approval AND Approve recurrent or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is a premenopausal, perimenopausal, or postmenopausal woman and Ibrance will be used in combination with anastrozole, exemestane, or letrozole 2. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Ibrance will be used in combination with anastrozole, exemestane or letrozole or Ibrance will be used in combination with fulvestrant 3. Pt is a premenopausal, perimenopausal, or postmenopausal woman AND Ibrance will be used in combination with fulvestrant.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ICATIBANT

## Products Affected

- *icatibant*
- *sajazir*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50 percent of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant - the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ICLUSIG

## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Philadelphia Chromosome-positive (Ph+) Acute Lymphoblastic Leukemia (ALL)-Approve if member meets one of the following A, B, C: A) Approve if member has newly diagnosed Ph+ ALL AND medication will be used in combination with chemotherapy B) Member has T315I-positive ALL or C) Requested medication will be used as monotherapy in members for whom no other TKIs are indicated. Chronic Myeloid Leukemia (CML)-Approve if member meets one of the following A, B, C: A) Member has chronic phase (CP) CML with resistance or intolerance to at least two prior kinase inhibitors B) Member has Accelerated phase (AP) or blast phase (BP) CML for whom no other kinase inhibitors are indicated or C) Member has T315I-positive CML (chronic, accelerated, or blast phase).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IDHIFA

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## Products Affected

- IDHIFA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	IDH2-mutation status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ILARIS

## Products Affected

- ILARIS (PF)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	When used in combination with concurrent biologic therapy (e.g. TNF antagonists, etanercept, adalimumab, certolizumab pegol, golimumab, infliximab), anakinra, or riloncept.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	CAPS-4 years of age and older. SJIA-2 years of age and older. Still's disease-18 years and older (Note-patients less than 18 should be referred to criteria for systemic juvenile idiopathic arthritis)
<b>Prescriber Restrictions</b>	CAPS/MWS/FCAS initial- Prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist. SJIA/Still's disease initial- prescribed by or in consultation with a rheumatologist. FMF initial - rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, hematologist. HIDS/MKD/TRAPS initial - rheumatologist, nephrologist, geneticist, oncologist, hematologist.
<b>Coverage Duration</b>	CAPS/SJIA-3 mos ini, 1yr cont. FMF/HIDS/MKD/TRAPS-4 mos ini, 1yr cont. Still's-3 mo ini, 1 yrcont
<b>Other Criteria</b>	For renewal of CAPS/MWS/FCAS/SJIA/FMF/HIDS/MKD/TRAPS/Still's - After pt had been started on Ilaris, approve if the pt had a response to therapy as determined by prescribing physician. SJIA, initial therapy - approve if the pt has tried at least one other biologic for SJIA (tocilizumab, abatacet, TNF antagonists (e.g. etanercept, adalimumab, infliximab)) or started on Ilaris while in the hospital. Adult Onset Still's Disease-Initial-approve if the patient has tried at least one other biologic or started on Ilaris while in the hospital. Acute gout flare- approve if (i and ii): (i) pt has intolerance, contraindication, or lack of response to NSAIDs and colchicine for the treatment of acute gout flares OR pt is unable to be retreated with a repeat course of corticosteroids (oral or injectable) for acute gout flare, and (ii) patient is receiving or will be taking concomitant urate lowering medication for prevention of gout unless contraindicated (ex: allopurinol, febuxostat, probenecid).
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IMATINIB

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## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For ALL/CML, must have Ph-positive for approval of imatinib. Myelodysplastic/myeloproliferative disease-approve if the condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IMBRUVICA

## Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 280 MG, 420 MG
- IMBRUVICA ORAL SUSPENSION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	GVHD-Approve if the patient has tried one or more conventional systemic treatments for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus). Chronic Lymphocytic Leukemia (CLL)/Small lymphocytic lymphoma (SLL) with or without 17p deletion-Approve. Waldenstrom macroglobulinemia (WM)-Approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IMKELDI

## Products Affected

- IMKELDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, Must have documentation showing that administration via nasogastric tube is required OR documentation of inability to swallow an intact tablet.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	Initial: Newly diagnosed Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML) in chronic phase-approve. Ph+ CML in blast crisis (BC), accelerated phase (AP), or in chronic phase (CP) after failure of interferon-alpha therapy-approve. Relapsed or refractory Ph+ acute lymphoblastic leukemia (ALL)-approve. Newly diagnosed Ph+ ALL- Approve if member is a pediatric patient AND medication will be used in combination with chemotherapy. Myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with platelet-derived growth factor receptor (PDGFR) gene re-arrangements-Approve for adult members. Aggressive systemic mastocytosis (ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown-Approve for adult members. Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL)-Approve for adult members who have the FIP1L1-PDGFR? fusion kinase (mutational analysis or fluorescence in situ hybridization [FISH] demonstration of CHIC2 allele deletion) OR members with HES and/or CEL who are FIP1L1-PDGFR? fusion kinase negative or unknown. Unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP)-approve for adult members. Gastrointestinal Stromal Tumors (GIST)-Approve if member has Kit (CD117) positive unresectable and/or metastatic, malignant tumors OR if requested medication will be used as adjuvant treatment for adult members following resection of Kit (CD117) positive GIST. Reauthorization:



<b>PA Criteria</b>	<b>Criteria Details</b>
	Member has responded positively to therapy as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IMPAVIDO

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## Products Affected

- IMPAVIDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy, Sjogren-Larsson-Syndrome
<b>Required Medical Information</b>	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 <i>Leishmania donovani</i> , (2) Cutaneous leishmaniasis due to <i>Leishmania braziliensis</i> , <i>Leishmania guyanensis</i> , and <i>Leishmania panamensis</i> , or (3) Mucosal leishmaniasis due to <i>Leishmania braziliensis</i> . Must have a trial and failure, contraindication or intolerance to Liposomal Amphotericin B prior to approval.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	30 Days
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	Yes

# INAVOLISIB

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## Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial: Member must have a diagnosis of endocrine-resistant, PIK3CA-mutated, hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test, following recurrence on or within 12 months of completing adjuvant endocrine therapy (i.e. tamoxifen, anastrozole, exemestane). Member must use requested medication in combination with palbociclib and fulvestrant. Reauthorization: Approve if the member has responded positively to therapy as determined by the prescribing physician
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# INCRELEX

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## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	(Reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# INJECTABLE TESTOSTERONE PRODUCTS

## Products Affected

- *testosterone cypionate*
- *testosterone enanthate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, lab results
<b>Age Restrictions</b>	Delayed puberty or induction of puberty in males-12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Delayed puberty or induction of puberty in males-6 months, all others-12 months
<b>Other Criteria</b>	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient 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. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. Delayed puberty or induction of puberty in males - Approve testosterone 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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# INLYTA

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## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Advanced Renal cell carcinoma-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# INQOVI

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## Products Affected

- INQOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# INREBIC

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## Products Affected

- INREBIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate-2 or high-risk disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IRESSA

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## Products Affected

- GEFITINIB

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC-Approve if the member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ISTURISA

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## Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Patient is not a candidate for pituitary surgery, OR b) Pituitary surgery has not been curative for the patient.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Cushing's disease (initial, reauth): 12 months
<b>Other Criteria</b>	Cushing's disease (reauth): 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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IVERMECTIN (ORAL)

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## Products Affected

- *ivermectin oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# IVIG

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## Products Affected

- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- OCTAGAM
- PANZYGA
- PRIVIGEN

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

# IWILFIN

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## Products Affected

- IWILFIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Neuroblastoma-Approve if the patient meets the following (A, B and C): A) Patient has high-risk disease, AND B) The medication is being used to reduce the risk of relapse, AND C) Patient has had at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# JAKAFI

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## Products Affected

- JAKAFI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	MF/PV-18 and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For polycythemia vera patients must have tried hydroxyurea. Polycythemia vera-approve if the patient has tried hydroxyurea.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# JAYPIRCA

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## Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Relapsed or Refractory Mantle Cell Lymphoma-Approve if the patient has tried at least one systemic regimen (i.e. rituximab, dexamethasone, cytarabine, carboplatin) AND one Bruton tyrosine kinase inhibitor (BTK inhibitor) (i.e. Brukinsa, Imbruvica, Calquence) for mantle cell lymphoma. Chronic Lymphocytic Leukemia (CLL)/Small lymphocytic lymphoma (SLL)-Approve if patient has received at least two prior lines of therapy, including a BTK inhibitor (i.e. Brukinsa, Imbruvica, Calquence) AND a B-Cell Lymphoma inhibitor (BCL-2 inhibitor) (i.e. Venclexta).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# JOENJA

## Products Affected

- JOENJA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of immunosuppressive therapy
<b>Required Medical Information</b>	Diagnosis, lab tests as noted in other criteria
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an immunologist or geneticist
<b>Coverage Duration</b>	Initial - 6 months Reauthorization - 12 months
<b>Other Criteria</b>	Initial criteria - Diagnosis of activated phosphoinositide 3-kinase (PI3K) delta syndrome (APDS) confirmed by both the following 1) Presence of an activated phosphoinositide 3-kinase delta syndrome (APDS)-associated genetic PI3K-delta mutation with a documented variant in either PIK3CD or PIK3R1 2) Submission of clinical findings and manifestations compatible with APDS (e.g., history of recurrent sinopulmonary infections, sinusitis, pneumonia, bronchitis, chronic Epstein-Barr virus and cytomegalovirus (CMV) viremia, autoimmune cytopenia, and/or lymphadenopathy/hepatomegaly) Re-authorization criteria - approve if member has experienced response to treatment as determined by prescriber
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# JUXTAPID

## Products Affected

- JUXTAPID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient must have a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by the following: Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) and had clinical manifestation of HoFH before the age of 10 years OR one of the member's biological parents had untreated (LDL-C levels or total cholesterol levels consistent with HeFH OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL and had clinical manifestation of HoFH before the age of 10 years OR one of the member's biological parents had untreated LDL-C levels or total cholesterol levels consistent with HeFH, AND member must be on a high-intensity statin (e.g., atorvastatin, simvastatin) unless intolerant or contraindicated AND another LDL-lowering medication from a different class (e.g., ezetimibe, colestipol) prior to starting lomitapide.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KALYDECO

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## Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Orkambi, Trikafta or Symdeko
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KANUMA

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## Products Affected

- KANUMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient lysosomal acid lipase activity in leukocytes, fibroblasts, or liver tissue OR a molecular genetic test demonstrating lysosomal acid lipase gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KERENDIA

## Products Affected

- KERENDIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Adrenal insufficiency. Concomitant treatment with strong CYP3A4 inhibitors.
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	At initiation of therapy must meet all of the following: 1) estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73m <sup>2</sup> AND 2) urinary albumin-to-creatinine ratio (UACR) of greater than or equal to 30mg/g AND 3) a serum potassium of less than or equal to 5mEQ/L. Must currently be receiving maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) unless there is a contraindication or significant side effect/toxicity to ACE or ARB therapy. Must have an inadequate response or significant side effects/toxicity or a contraindication to the SGLT-2 inhibitor used for chronic kidney disease (e.g. Farxiga). For reauth: documentation from the provider that the member's condition has stabilized or improved based upon the prescriber's assessment while on therapy and/or attestation from provider that serum potassium is being monitored while on therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KESIMPTA

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## Products Affected

- KESIMPTA PEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Active hepatitis B infection
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approved if member has diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Must not have evidence of infection. Must not have history of progressive multifocal leukoencephalopathy (PML). Must not be on current concomitant therapy with antineoplastic, immunosuppressive or immune modulating therapies. Must have had inadequate response or intolerance to ONE of the following: dimethyl fumarate, fingolimod, teriflunomide, or glatiramer. Reauth: Must have documentation from prescriber indicating stabilization or improvement of condition
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KISQALI

## Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Breast cancer (early)-Approve if member has hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative stage II and III early breast cancer at high risk of recurrence AND medication will be used as adjuvant treatment in combination with an aromatase inhibitor (i.e. anastrozole, exemestane, letrozole). Breast cancer (advanced or metastatic)-Approve if member is diagnosed with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer AND medication will be used in combination with: 1) an aromatase inhibitor as initial endocrine-based therapy (i.e. anastrozole, exemestane, letrozole) OR 2) fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# KORLYM

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## Products Affected

- *mifepristone oral tablet 300 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior surgeries
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
<b>Coverage Duration</b>	Endogenous Cushing's Synd-1 yr.
<b>Other Criteria</b>	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if mifepristone is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# KOSELUGO

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## Products Affected

- KOSELUGO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment). Patient is able to swallow a capsule whole.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: oncologist or neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# KRAZATI

## Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an approved test AND has been previously treated with at least one systemic regimen. Note: Examples of systemic regimens include those containing one or more of the following products: Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Alimta (pemetrexed intravenous infusion), Yervoy (ipilimumab intravenous infusion), Abraxane (albumin-bound paclitaxel intravenous infusion), bevacizumab, cisplatin, carboplatin, docetaxel, gemcitabine, paclitaxel, vinorelbine. Colorectal Cancer (CRC)-approve if member has meets all criteria A,B, C: A) member has KRAS G12C-mutated locally advanced or metastatic CRC, 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

# LAPATINIB

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## Products Affected

- *lapatinib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	HER2-positive recurrent or metastatic breast cancer, approve if lapatinib will be used in combination with capecitabine and the patient has tried at least two prior anti-HER2 based regimens OR the medication will be used in combination with an aromatase inhibitor and the patient has HR+ disease and the patient is a postmenopausal woman.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LAZERTINIB

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## Products Affected

- LAZCLUZE ORAL TABLET 240 MG,  
80 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 Months
<b>Other Criteria</b>	Initial Criteria: Member must have chart note documentation with diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations, as detected by an FDA-approved test. Requested medication must be used in combination with amivantamab. Provider attests anticoagulant prophylaxis will be administered for the first four months of treatment. Reauthorization Criteria: Approve if the member has responded positively to therapy, without disease progression or unacceptable toxicity, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LENVIMA

## Products Affected

- LENVIMA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	DTC - must be refractory to radioactive iodine treatment for approval. RCC, advanced disease - approve if the pt meets i or ii:i. Lenvima is being used in combination with pembrolizumab OR ii. Lenvima is used in combination with everolimus and the patient meets the following: Patient has clear cell histology and patient has tried one antiangiogenic therapy. Endometrial Carcinoma-Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND B) The medication is used in combination with Keytruda (pembrolizumab for intravenous injection) AND C)the disease has progressed on at least one prior systemic therapy AND D) The patient is not a candidate for curative surgery or radiation. HCC-Approve
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LIBERVANT

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## Products Affected

- LIBERVANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Acute-narrow angle glaucoma
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Pediatrics 2 to 5 years old
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must have a diagnosis of intermittent, stereotypic episodes of frequent seizure activity (i.e. seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern. Member must currently be receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LIDOCAINE PATCH

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LIVMARLI

## Products Affected

- LIVMARLI ORAL SOLUTION 19 MG/ML, 9.5 MG/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	PFIC Type 2 with specific ABCB11 variant resulting in non-functional or complete absence of bile salt export pump (BSEP) protein OR patients with prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ALGS (initial): Prescribed by or in consultation with a hepatologist. PFIC: Hepatologist, gastroenterologist, or a physician who specializes Progressive Familial Intrahepatic Cholestasis (PFIC)
<b>Coverage Duration</b>	ALGS (initial, reauth): 12 months. PFIC-Initial-6 months Reauth-12 months
<b>Other Criteria</b>	Initial-Alagille Syndrome-Approve if member has a diagnosis of cholestatic pruritis associated with Alagille Syndrome. Must provide results of genetic testing confirming a JAG1 or NOTCH2 deletion or mutation. Must submit chart note documentation or labs showing two or more of the following: total serum bile acid greater than 3 times the upper limit normal (ULN) for age, conjugated bilirubin greater than 1 mg/dL, fat soluble vitamin deficiency otherwise unexplainable, GGT greater than 3 times ULN for age, intractable pruritis explainable only by liver disease. Must have trial with an inadequate response or significant side effect OR contraindication to at least TWO medications for ALGS-associated pruritis (e.g. ursodeoxycholic acid (Ursodiol), rifampin). Must provide baseline Itch Reported Outcome (ItchRO)score. Must provide current weight. Must request dose that falls within the recommended dosing guidelines from the manufacturer. Reauthorization-ALGS-Approve if chart note documentation from the provider supports the condition has improved while on therapy (i.e. reduction in serum bile acids from baseline, decrease in baseline pruritis score) and the member continues to benefit from therapy. Must provide current weight. Must request dose that falls within the



<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>recommended dosing guidelines from the manufacturer. Progressive Familial Intrahepatic Cholestasis (PFIC)-Approve if member has a diagnosis of PFIC. Must provide weight and request dose that falls within the recommended dosing guidelines from the manufacturer. Must provide results of genetic testing demonstrating a gene mutation affiliated with PFIC (e.g. ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, MYO5B). Must submit labs documenting the total serum bile salt concentration above the upper limit of normal. Must provide baseline Itch Reported Outcome (ItchRO) score. Must have a documented trial with an inadequate response or significant side effect or documented contraindication to at least ONE medication for PFIC-associated pruritis (e.g. rifampicin, cholestyramine, ursodeoxycholic acid (Ursodiol) AND Odevixibat (Bylvay).</p> <p>Reauthorization-PFIC-Approve if chart note documentation from the provider supports the condition has improved while on therapy (i.e. reduction in serum bile acids from baseline, decrease in baseline pruritis score) and the member continues to benefit from therapy. Must provide current weight. Must request dose that falls within the recommended dosing guidelines from the manufacturer.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LIVTENCITY

## Products Affected

- LIVTENCITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis. Must have received a solid organ transplant or hematopoietic stem cell transplant. Must weigh at least 35kg. Must have chart documentation of at least ONE of the following: cytomegalovirus (CMV) DNA level in whole blood or plasma that has not decreased by greater than or equal to 1 log <sub>10</sub> (e.g., a 10 fold decrease, reduction by 90%) after 14 days of antiviral therapy at the treatment dose OR dose limiting toxicity preventing the continuation of current antiviral therapy (e.g. bone marrow suppression, renal toxicity). Must not be used concomitantly with ganciclovir or valganciclovir. Must not have CMV disease involving the central nervous system (including the retina). Reauthorization: must have chart documentation from the provider that the member's condition has improved based upon the prescriber's assessment while on therapy or the member continues to benefit from therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Hematologist, oncologist, infectious disease physician, or transplant physician
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	For requests for doses that exceed 400mg twice daily: must be administered with carbamazepine, phenytoin, or phenobarbital AND must follow recommended dosing in the prescribing information
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LODOCO

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## Products Affected

- LODOCO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pre-existed blood dyscrasias, renal failure, severe hepatic impairment, and concurrent use of strong CYP3A4 or P-gp inhibitors
<b>Required Medical Information</b>	Diagnosis, medical history of cardiovascular disease as noted in criteria
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a physician specializing in heart disease (e.g. cardiologist, lipidologist)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member has a diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) confirmed by a history of myocardial infarction OR at least one of the following: a history of an acute coronary syndrome, stable or unstable angina, history of stroke, history of transient ischemic attack, peripheral arterial disease presumed to be of atherosclerotic origin, member has undergone coronary or other arterial revascularization procedure in the past (e.g., coronary artery bypass graft surgery, percutaneous coronary intervention, angioplasty, and coronary stent procedures)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LONG ACTING OPIOIDS

## Products Affected

- *buprenorphine*
- *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*
- *morphine oral tablet extended release*
- OXYCONTIN ORAL TABLET, ORAL ONLY, EXT.REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Acute (ie, non-chronic) pain
<b>Required Medical Information</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, in hospice, sickle cell disease or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LONSURF

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## Products Affected

- LONSURF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Gastric or Gastroesophageal Junction Adenocarcinoma-approve if the patient has been previously treated with at least two chemotherapy regimens for gastric or gastroesophageal junction adenocarcinoma. Colon and rectal cancer-approve per labeling if the patient has been previously treated with a fluoropyrimidine, oxaliplatin and irinotecan. If the patient's tumor or metastases are wild-type RAS (KRAS wild type and NRAS wild type) they must also try Erbitux or Vectibix.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LORBRENA

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## Products Affected

- LORBRENA ORAL TABLET 100 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, ALK status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LOTRONEX

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## Products Affected

- *alosetron*

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



# LUMAKRAS

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LUMIZYME

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## Products Affected

- LUMIZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue OR patient has a molecular genetic test demonstrating acid alpha-glucosidase gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LYNPARZA

## Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	<p>Ovarian Cancer - Treatment-initial-Approve if the patient meets the following criteria: The patient has a germline BRCA-mutation as confirmed by an approved test. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if the patient meets one of the following criteria (A or B): A) The patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. The patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B) The patient is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). Ovarian, fallopian tube, or primary peritoneal cancer-maintenance, combination therapy-approve if the medication is used in combination with bevacizumab, the patient has homologous recombination deficiency (HRD)-positive disease, as confirmed by an approved test and the patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Breast cancer, adjuvant-approve if the patient has germline BRCA mutation-positive, HER2-negative breast cancer and the patient has tried neoadjuvant or adjuvant therapy. Breast cancer, recurrent or metastatic disease-approve if the patient has recurrent or metastatic disease,</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>has germline BRCA mutation-positive breast cancer and the patient has HER2-negative breast cancer. Pancreatic Cancer-maintenance therapy-approve if the patient has a germline BRCA mutation-positive metastatic disease and the disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. Prostate cancer-castration resistant-approve if the patient meets one of the following criteria (A or B): A)metastatic disease, the medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog or the patient has had a bilateral orchiectomy, the patient has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test, the patient does not have a PPP2R2A mutation and the patient has been previously treated with at least one androgen receptor directed therapy. B) germline BRCA mutation-positive metastatic disease, the medication is used in combination with abiraterone and prednisone or prednisolone for the treatment of adult patients.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# LYTGOBI

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## 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
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease, tumor has fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements as detected by an approved test and if the patient has been previously treated with at least one systemic regimen. Note: Examples of systemic regimens include gemcitabine + cisplatin, 5-fluorouracil + oxaliplatin or cisplatin, capecitabine + cisplatin or oxaliplatin, gemcitabine + Abraxane (albumin-bound paclitaxel) or capecitabine or oxaliplatin, and gemcitabine + cisplatin + Abraxane.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MAVYRET

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## Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

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

# MEGACE

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## Products Affected

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

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

# MEKINIST

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery.For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafinlar, unless intolerant AND the patient has BRAF V600-positive disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# MEKTOVI

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## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, BRAF V600 status, concomitant medications
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi. NSCLC-approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Braftovi (encorafenib capsules).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MEMANTINE

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Indication for which memantine is being prescribed.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MEPSEVII

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## Products Affected

- MEPSEVII

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient beta-glucuronidase activity in leukocytes, fibroblasts, or serum OR has a molecular genetic test demonstrating glucuronidase gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# METHYLERGONOVINE

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## Products Affected

- *methylergonovine oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MODAFINIL/ARMODAFINIL

## Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Excessive daytime sleepiness associated with narcolepsy-prescribed by or in consultation with a sleep specialist physician or neurologist
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD)-approve if the patient is working at least 5 overnight shifts per month. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome-approve. Excessive daytime sleepiness associated with Narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MYALEPT

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## Products Affected

- MYALEPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# MYCAPSSA

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## Products Affected

- MYCAPSSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) Inadequate response to surgical resection and/or pituitary irradiation, or 2) Patient is not a candidate for surgical resection or pituitary irradiation. Patient has responded to and tolerated treatment with octreotide or lanreotide.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Acromegaly (initial, reauth): 12 months
<b>Other Criteria</b>	Acromegaly (reauth): Documentation of positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NAGLAZYME

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## Products Affected

- NAGLAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating arylsulfatase B gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# NAYZILAM

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## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NERLYNX

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## Products Affected

- NERLYNX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Stage of cancer, HER2 status, previous or current medications tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Adjuvant tx-Approve for 1 year (total), advanced or metastatic disease-3yrs
<b>Other Criteria</b>	Breast cancer, adjuvant therapy - approve if the patient meets all of the following criteria: patient will not be using this medication in combination with HER2 antagonists, patient has HER2-positive breast cancer AND Patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy. Breast cancer, recurrent or metastatic disease-approve if the patient has HER-2 positive breast cancer, Nerlynx will be used in combination with capecitabine and the patient has tried at least two prior anti-HER2 based regimens.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NEXAVAR

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## Products Affected

- *sorafenib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Renal cell carcinoma (RCC)-approve if the patient has relapsed or Stage IV clear cell histology and the patient has tried at least one prior systemic therapy (e.g., Inlyta, Votrient, Sutent Cabometyx).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NEXLETOL

## Products Affected

- NEXLETOL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	<p>Heterozygous Familial Hypercholesterolemia (HeFH)-approve if pt meets one of the following: patient has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR patient has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR patient has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.</p> <p>Atherosclerotic Cardiovascular Disease (ASCVD) -approve if pt is unable to take recommended statin therapy (including those not taking a statin) with established cardiovascular disease (CVD) defined as: history of</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	coronary artery disease, prior MI, history of ACS, diagnosis of angina (stable or unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure OR at a high risk for a CVD event i.e family history of premature ASCVD, primary hypercholesterolemia (LDL-C 160--189), metabolic syndrome, CKD, chronic inflammatory conditions, history of premature menopause and pregnancy-associated conditions that increase later ASCVD risk, high-risk races/ethnicities, lipid/biomarkers associated with increased ASCVD risk, and diabetes-specific high-risk features but without established CVD.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NEXLIZET

## Products Affected

- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	<p>Heterozygous Familial Hypercholesterolemia (HeFH) -approve if pt meets one of the following: has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. Atherosclerotic Cardiovascular Disease (ASCVD) -approve if pt is unable to take recommended statin therapy (including those not taking a statin) with established cardiovascular disease (CVD) defined as: history of coronary artery disease, prior MI, history of ACS,</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	diagnosis of angina (stable or unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure OR at a high risk for a CVD event i.e family history of premature ASCVD, primary hypercholesterolemia (LDL-C 160--189), metabolic syndrome, CKD, chronic inflammatory conditions, history of premature menopause and pregnancy-associated conditions that increase later ASCVD risk, high-risk races/ethnicities, lipid/biomarkers associated with increased ASCVD risk, and diabetes-specific high-risk features but without established CVD.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NILOTINIB TARTRATE

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## Products Affected

- DANZITEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Members with hypokalemia, hypomagnesemia, or long QT syndrome
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Newly diagnosed Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML)-Approve if in chronic phase. Chronic Phase (CP) or Accelerated Phase (AP) Ph+ CML-Approve if resistant to or intolerant to prior therapy that included imatinib. Reauthorization: Member has responded positively to therapy as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# NILUTAMIDE

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## Products Affected

- *nilutamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NINLARO

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## Products Affected

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Multiple Myeloma-Approve if the member has a diagnosis of MM AND member has received at least one prior therapy for MM AND medication will used in combination with lenalidomide and dexamethasone
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NITISINONE

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## Products Affected

- *nitisinone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant therapy with nitisinone products
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Hereditary Tyrosinemia, Type 1-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NIVESTYM

## Products Affected

- NIVESTYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cancer/AML, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN - hematologist.
<b>Coverage Duration</b>	chemo/SCN/AML-6mo.PBPC,BMT-3mo. Other=12mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# NON-INJECTABLE TESTOSTERONE PRODUCTS

## Products Affected

- *testosterone transdermal gel* 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- *testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal solution in metered pump w/app*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram),*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient 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. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NORTHERA

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## Products Affected

- *droxidopa*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history of midodrine
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# NUBEQA

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## Products Affected

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Prostate cancer - non-metastatic, castration resistant-approve if the requested medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy. Prostate cancer-metastatic, castration sensitive-approve if the medication is used in combination with docetaxel and the medication will be used in combination with a GnRH agonist or in combination with Firmagon or if the patient had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NUCALA

## 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
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Asthma-6 years of age and older. EGPA/Polyps-18 years of age and older. HES-12 years and older.
<b>Prescriber Restrictions</b>	Asthma-Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA-prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist. HES-prescribed by or in consultation with an allergist, immunologist, hematologist, pulmonologist or rheumatologist. Polyps-prescribed by or in consult with allergist, immunologist or Otolaryngologist.
<b>Coverage Duration</b>	Initial-Asthma/EGPA/polyps-6 months, HES-8 months. 12 months continuation.
<b>Other Criteria</b>	Asthma initial - must have blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 wks (prior to tx with any anti-IL-5) AND has received combo tx w/inhaled corticosteroid AND at least 1 additional asthma controller/maintenance med AND pt's asthma cont to be uncontrolled, or was uncontrolled prior to starting any anti-IL tx as defined by 1 of following-pt experi 2 or more asthma exacer req tx w/systemic corticosteroids in prev yr, pt experienced 1 or more asthma exacer requiring hospitalization or ED visit in the prev yr, pt has a FEV1 less than 80 percent predicted, Pt has FEV1/FVC less than 0.80, or Pt's asthma worsens upon taper of oral corticosteroid therapy.NOTE:An exception to requirement for trial of 1 additional asthma controller/maintenance med can be made if pt has already received anti-IL-5 tx used concomitantly with an ICS.Cont-pt responded to Nucala tx as determined by the prescribing physician AND Pt cont to receive tx with an inhaled corticosteroid. EGPA initial-approve if pt has active, non-severe disease, has/had a blood eosinophil level of greater than or equal to 150

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>cells per microliter within the previous 6 wks or within 6 wks prior to tx w/any anti-IL-5 tx. Cont-pt responded to Nucala tx as determined by the prescribing physician.HES initial-pt has had hypereosinophilic synd for greater than or equal to 6 months AND has FIP1L1-PDGFRalpha-negative dis AND pt does NOT have identifiable non-hematologic secondary cause of hypereosinophilic synd AND prior to initiating tx with any anti-IL-5 tx, pt has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter. Cont-approve if the patient has responded to Nucala tx. Nasal polyps, initial-approve if pt meets ALL of the following criteria(A, B, C and D):A) pt has chronic rhinosinusitis w/nasal polyposis as evidenced by direct examination, endoscopy, or sinus CT scan AND B)pt experienced 2 or more of the following sympt for at least 6 months:nasal congest/obstruct/discharge, and/or reduction/loss of smell AND C)pt meets BOTH of the following (a and b): a)Pt has received tx with intranasal corticosteroid AND b)Pt will continue to receive tx with intranasal corticosteroid concomitantly with Nucala AND D)pt meets 1 of the following (a, b or c): a)Pt has received at least 1 course of tx with a systemic corticosteroid for 5 days or more within the previous 2 years, OR b)Pt has a contraindication to systemic corticosteroid tx, OR c)Pt had prior surgery for nasal polyps.Cont-approve if the pt has received at least 6 months of therapy, continues to receive tx with an intranasal corticosteroid and has responded to tx.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NUEDEXTA

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## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NUPLAZID

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## Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NURTEC

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## Products Affected

- NURTEC ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acute Migraine-Approve if patient has tried at least two generic triptans with inadequate responses to those therapies or the patient has a contraindication or intolerance to triptans . Episodic Migraine Prevention-Approve if the patient has greater than or equal to 4 but less than 15 migraine headache days per month (prior to initiating a migraine preventive medication and has tried at least TWO standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# NYVEPRIA

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## Products Affected

- NYVEPRIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	Cancer pts receiving chemo-6 mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if - the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OCALIVA

## Products Affected

- OCALIVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
<b>Age Restrictions</b>	18 years and older (initial)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial)
<b>Coverage Duration</b>	6 months initial, 1 year cont.
<b>Other Criteria</b>	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# OCREVUS

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## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other Disease-Modifying Agents used for MS
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older (initial/continuation)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with, a physician who specializes in the treatment of MS and/or a neurologist (initial/continuation)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Relapsing forms of MS-Patients new to therapy-approve if the patient had a trial with generic dimethyl fumarate prior to approval of Ocrevus. (Note: Prior treatment with Tecfidera, Bafiertam or Vumerity also counts. Also, a patient who has previously tried a glatiramer product (Copaxone, Glatopa, generic) or Lemtrada, Tysabri or Kesimpta can bypass the requirement of a trial of generic dimethyl fumarate). Continuation-approve if the patient has responded to therapy. Primary progressive MS-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OCTREOTIDE INJECTABLE

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## Products Affected

- *octreotide acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescr/consult w/endocrinologist. NETs-prescr/consult w/oncologist, endocrinologist, or gastroenterologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. Patient has had an inadequate response to surgery and/or radiotherapy OR ii. Patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. Patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND 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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ODOMZO

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## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	BCC - Must not have had disease progression while on Erivedge (vismodegib).
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OFEV

## Products Affected

- OFEV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45 percent of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10 percent of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OGSIVEO

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## Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. Chart documentation as noted in other criteria.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve if member has a diagnosis of desmoid tumor that requires systemic treatment. Must have chart note documentation of tumor progression.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OJEMDA

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## Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6)
- OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis and BRAF V600 status
<b>Age Restrictions</b>	Pediatrics 6 months - 21 years of age
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve if member has relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OJJAARA

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## Products Affected

- OJJAARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Myelofibrosis-approve if the patient has intermediate-risk or high-risk disease and the patient has anemia, defined as hemoglobin less than 10g/dL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OLPRUVA

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## Products Affected

- OLPRUVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Ravicti and Buphenyl
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member has a confirmed diagnosis of chronic hyperammonemia due to a urea cycle disorder (UCD) amenable to treatment with sodium phenylbutyrate as verified by genetic, enzymatic or biochemical testing (submit labs confirming diagnosis)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ONUREG

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## Products Affected

- ONUREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML - Approve if the patient meets the following criteria (both A and B): A) Following intensive induction chemotherapy, the patient achieves one of the following according to the prescriber (i or ii): i. First complete remission OR ii. First complete remission with incomplete blood count recovery AND B) Patient is not able to complete intensive curative therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OPSUMIT

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## Products Affected

- OPSUMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PAH WHO group, right heart catheterization results, WHO functional status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OPSYNVI

## Products Affected

- OPSYNVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy, Concomitant Organic Nitrates, or Guanylate Cyclase Stimulators
<b>Required Medical Information</b>	Platelet and hemoglobin counts prior to initiating therapy, PAH WHO group, right heart catheterization results, WHO functional status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a clinician with expertise in treating patients with pulmonary arterial hypertension
<b>Coverage Duration</b>	6 months (initial) 12 months (continuation)
<b>Other Criteria</b>	Initial: Member has a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 meeting Functional Class II or III. Diagnosis has been confirmed with hemodynamic definitions obtained from a right heart catheterization (RHC) and chart notes documenting the following a, b, and c: a) mean arterial pressure (mPAP) measured greater than or equal to 20mmHg at rest b) pulmonary artery wedge pressure (PAWP) measured less than or equal to 15 mmHg c) pulmonary vascular resistance (PVR) greater than or equal to 2 woods units. Provider must attest the member does not have severe hepatic impairment or creatinine clearance 15-29 mL/min. Must have baseline negative pregnancy test prior to initiation of therapy if a natal female of reproductive potential. Member must have a trial and failure, intolerance, or contraindication to ambrisentan or bosentan OR member is established on Opsumit (macitentan) Reauth: Approve if the patient has responded to therapy as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORENCIA

## Products Affected

- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). PsA, initial -approve. Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], initial - approve if the patient has tried one other agent for this condition or the patient will be starting on Orencia concurrently with methotrexate, sulfasalazine or leflunomide or the patient has an absolute contraindication to methotrexate, sulfasalazine or leflunomide or the patient has aggressive disease as determined by the prescribing physician. Cont tx - responded to therapy as per the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORENITRAM

## Products Affected

- ORENITRAM MONTH 1 TITRATION KT
- ORENITRAM MONTH 2 TITRATION KT
- ORENITRAM MONTH 3 TITRATION KT
- ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG
- *orenitram oral tablet extended release 0.25 mg, 1 mg, 2.5 mg, 5 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORGOVYX

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## Products Affected

- ORGOVYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Prostate Cancer-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORILISSA

## Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM) (initial - 150 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence. EM (200 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM (init, reauth-150mg): 6 mo. EM (200mg): 6 mo.
<b>Other Criteria</b>	EM (reauthorization - 150 mg): Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain). Treatment duration has not exceeded a total of 24 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORKAMBI

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## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Kalydeco, Trikafta or Symdeko.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ORLADEYO

## Products Affected

- ORLADEYO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Takhzyro).
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders. (initial and continuation)
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Prophylaxis, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Continuation-According to the prescriber the patient has had a favorable clinical response since initiating Orladeyo prophylactic therapy compared with baseline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ORSERDU

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## Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Breast cancer in postmenopausal women or Men-approve if the patient meets the following criteria (A, B, C, D, and E): A) Patient has recurrent or metastatic disease, AND B) Patient has estrogen receptor positive (ER+) disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative disease, AND D) Patient has estrogen receptor 1 gene (ESR1)-mutated disease, AND E) Patient has tried at least one endocrine therapy. Note: Examples of endocrine therapy include fulvestrant, anastrozole, exemestane, letrozole, and tamoxifen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OTEZLA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous drugs tried
<b>Age Restrictions</b>	Plaque Psoriasis-6 years and older- All other indications-18 years and older
<b>Prescriber Restrictions</b>	All dx-initial only-PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist. Behcet's-prescribed by or in consultation with a dermatologist or rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to step back and try a conventional DMARD first). Behcet's-patient has oral ulcers or other mucocutaneous involvement AND patient has tried at least ONE other systemic therapy. PsA/PP/Behcet's- cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# OXERVATE

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## Products Affected

- OXERVATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Treatment duration greater than 16 weeks per affected eye(s)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by an ophthalmologist or an optometrist.
<b>Coverage Duration</b>	Initial-8 weeks, continuation-approve for an additional 8 weeks
<b>Other Criteria</b>	Patients who have already received Oxervate-approve if the patient has previously received less than or equal to 8 weeks of treatment per affected eye(s) and the patient has a recurrence of neurotrophic keratitis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PANRETIN

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## Products Affected

- PANRETIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Kaposi Sarcoma-approve if the patient is not receiving systemic therapy for Kaposi Sarcoma.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PEMAZYRE

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## Products Affected

- PEMAZYRE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease and the tumor has a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PENICILLAMINE

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## Products Affected

- *penicillamine oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PHENYL BUTYRATE

## Products Affected

- PHEBURANE
- RAVICTI
- *sodium phenylbutyrate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of Ravicti and Buphenyl
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Urea cycle disorders-approve if genetic or enzymatic testing confirmed a urea cycle disorder or if the patient has hyperammonemia diagnosed with an ammonia level above the upper limit of the normal reference range for the reporting laboratory.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# PHEOCHROMOCYTOMA

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## Products Affected

- *metyrosine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior medication trials
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for metyrosine)
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	If the requested drug is metyrosine for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

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## Products Affected

- *alyq*
- *sildenafil (pulmonary arterial hypertension) intravenous solution 10 mg/12.5 ml*
- *sildenafil (pulmonary arterial hypertension) oral tablet 20 mg*
- *tadalafil (pulmonary arterial hypertension) oral tablet 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, right heart cath results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PIMECROLIMUS (TOPICAL)

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## Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) AND generic tacrolimus (topical) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PIQRAY

## Products Affected

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

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

# PITOLISAN

## Products Affected

- WAKIX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Severe hepatic impairment (Child-Pugh C)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	EDS: 6 years and older, Narcolepsy w/cataplexy: 18 years and older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with neurologist, pulmonologist, psychiatrist, or sleep specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial- Narcolepsy with Cataplexy-Approve if member has a diagnosis of narcolepsy with cataplexy confirmed by submitted polysomnographic evaluation (i.e sleep study) with subsequent Multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 8 minutes and two or more sleep onset rapid eye movement periods (SOREMPs) including any SOREMP on the polysomnographic evaluation from the preceding night. Must provide number of cataplexy episodes at baseline. Excessive Daytime Sleepiness-Approve if member has a diagnosis of excessive daytime sleepiness associated with narcolepsy confirmed by submitted polysomnographic evaluation (i.e sleep study) with subsequent Multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 8 minutes and two or more sleep onset rapid eye movement periods (SOREMPs) including any SOREMP on the polysomnographic evaluation from the preceding night. For members less than 18 years of age, must have a trial and failure of modafinil. For members 18 years or older, must have a trial and failure of either modafinil or armodafinil AND a trial and failure of solriamfetol (Sunosi). Reauth-must have documentation from prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# PLEGRIDY

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## 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
<b>Exclusion Criteria</b>	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	Relapsing forms of multiple sclerosis (MS)-Approve
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# POMALYST

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## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Kaposi Sarcoma/MM-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Kaposi Sarcoma-Approve if the patient meets one of the following (i or ii): i. patient is Human Immunodeficiency Virus (HIV)-negative OR ii. patient meets both of the following (a and b): a) The patient is Human Immunodeficiency Virus (HIV)-positive AND b) The patient continues to receive highly active antiretroviral therapy (HAART). MM-approve if the patient has received at least one other Revlimid (lenalidomide tablets)-containing regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# POSACONAZOLE (ORAL)

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Aspergillus/Candida prophylaxis-6 months, all others-3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PREVYMIS

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## Products Affected

- PREVYMIS INTRAVENOUS
- PREVYMIS ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with pimozide and/or ergot alkaloids or with pitavastatin and simvastatin when co-administered with cyclosporine
<b>Required Medical Information</b>	Diagnosis. For reauth: no reauthorization is granted after initial coverage period.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Hematologist, infectious disease physician, oncologist, or transplant physician
<b>Coverage Duration</b>	210 days
<b>Other Criteria</b>	Treatment duration must not exceed 200 days post-transplant.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PROLIA

## Products Affected

- PROLIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient 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, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture . Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer, approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PROMACTA

## Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Myelodysplastic Syndrome (MDS)
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP, Aplastic Anemia-Hematologist or oncologist. Hepatitis C-Gastroenterologist, hematologist, hepatologist, or infectious disease specialist.
<b>Coverage Duration</b>	All indications-Initial-6 months Continuation-12 months
<b>Other Criteria</b>	Initial-First-Line Severe Aplastic Anemia (SAA)-Approve if member has diagnosis of SAA as evidenced by TWO of the following i, ii, iii: i) Absolute neutrophil count (ANC) less than $0.5 \times 10^9/L$ , ii) Platelet count is less than $20 \times 10^9/L$ , iii) Reticulocyte count less than 1% corrected or less than $60 \times 10^9/L$ AND must submit documentation confirming platelet levels are less than $50 \times 10^9/L$ AND medication must be used in combination with standard immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin). Refractory Severe Aplastic Anemia (SAA)-Approve if member has diagnosis of SAA as evidenced by TWO of the following i, ii, iii: i) Absolute neutrophil count (ANC) less than $0.5 \times 10^9/L$ , ii) Platelet count is less than $20 \times 10^9/L$ , iii) Reticulocyte count less than 1% corrected or less than $60 \times 10^9/L$ AND must submit documentation confirming platelet levels are less than $50 \times 10^9/L$ AND member must have a trial with an inadequate response or significant side effect to immunosuppressive therapy (e.g. cyclosporine, antithymocyte, cyclophosphamide). Chronic Hepatitis C Infection-Associated Thrombocytopenia-Approve if member has diagnosis AND documentation submitted confirming platelet levels are less than $75 \times 10^9/L$ . Provider attests requested medication will be used to achieve the target platelet count necessary to initiate antiviral therapy and to avoid reductions in

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>concomitant interferon-based therapy. Chronic Immune Thrombocytopenia (ITP)-Approve if member has diagnosis of ITP AND has had an insufficient response to corticosteroids (i.e. 0.5-2.0 mg/kg prednisone per day), immunoglobulins (IVIG), or splenectomy. Provider must attest the degree of thrombocytopenia and clinical condition increases the risk for bleeding. Reauthorization-Chronic Hepatitis C Infection-Associated Thrombocytopenia-Approve if member continues to receive interferon-based therapy. Reauthorization All Other Indications (including Chronic Hepatitis C Infection-Associated Thrombocytopenia)-Approve if platelet count meets one of the following i, ii, iii: i) less than 50 x 10<sup>9</sup>/L, ii) greater than or equal to 50 x 10<sup>9</sup>/L to 200 x 10<sup>9</sup>/L, iii) greater than or equal to 200 x 10<sup>9</sup>/L to less than or equal to 400 x 10<sup>9</sup>/L with an adjustment to reduce daily dose AND provider attests to regularly monitoring liver function and hematology laboratory tests. Provider attests member is not experiencing any signs or symptoms of hepatic injury or thromboembolism AND the requested medication will not be used in combination with another thrombopoietin receptor agonist or with Tavalisse (fostamatinib).</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# PYRIMETHAMINE

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## Products Affected

- *pyrimethamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# QINLOCK

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## Products Affected

- QINLOCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Gastrointestinal stromal tumor (GIST), advanced-approve if, the patient has two of the following imatinib, sunitinib, Sprycel or Stivarga OR if the patient has tried Ayvakit and Sprycel.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# QULIPTA

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## Products Affected

- QULIPTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has greater than or equal to 4 but less than 15 migraine headache days per month (prior to initiating a migraine preventive medication and has tried at least TWO standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RADICAVA

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## Products Affected

- RADICAVA
- RADICAVA ORS
- RADICAVA ORS STARTER KIT SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, ALSFRS-R
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Amyotrophic lateral sclerosis (ALS) - patient must meet criteria 1 and 2: 1) Functionality retained for most activities of daily living (defined as score of 2 points or better on each individual item of the ALDFRS-R.) AND 2) Normal respiratory function confirming patient has a Forced Vital Capacity (%FVC) greater than or equal to 80% at the start of treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REMICADE

## Products Affected

- REMICADE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medication, previous medications tried
<b>Age Restrictions</b>	CD and UC, Pts aged 6 years or more (initial therapy). PP-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx-initial therapy only-Prescribed by or in consult w/RA/AS/Still's/JIA/JRA-rheumatol.Plaque Psor/Pyoderma gangrenosum/HS-dermatol.Psoriatic Arthritis-rheumatol or dermatol.CD/UC-gastroenterol.Uveitis-ophthalmol.GVHD-transplant center, oncol, or hematol.Behcet's- rheumatol, dermatol,ophthalmol, gastroenterol, or neurol.Sarcoidosis-pulmonol, ophthalmol, or dermatol, cardio/neuro.
<b>Coverage Duration</b>	FDAind ini-3 mo,cont1yr,GVHD ini-1 mo,cont-3 mo,Pyo Gang-ini4 mo,cont1 yr,others-ini 3mo,cont-12 mo
<b>Other Criteria</b>	RA initial, patient has tried ONE conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). CD approve if the pt has tried corticosteroid (CS) or if CSs contraindicated or if currently on CS or if the patient has tried one other conventional systemic therapy for CD OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR the patient has had ileocolonic resection.Note-a previous trial of a biologic also counts as a trial of one other agent for CD. Ulcerative colitis (UC).Tried one systemic agent or was intolerant to one of these agents OR the patient has pouchitis AND has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Note-a previous trial of a biologic also counts as a trial of one systemic agent for UC. Behcet's.Pt has tried at least one conventional tx (eg, systemic CSs, immunosuppressants [e.g., AZA, MTX, MM, CSA, tacrolimus, chlorambucil, cyclophosphamide] or interferon alfa). NOTE: An exception to the

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>requirement for a trial of one conventional therapy can be made if the patient has already had a trial of at least one tumor necrosis factor for Behcet's disease. These patients who have already tried a biologic for Behcet's disease are not required to "step back" and try a conventional therapy) OR has ophthalmic manifestations. SD.Tried CS AND 1 conventional synthetic DMARD (eg, MTX) for 2 mos, or was intolerant.UV.Tried periocular/intraocular CS, systemic CS, immunosuppressant (eg, MTX, MM, CSA, AZA, CPM), etanercept, adalimumab. Sarcoidosis.Tried CS and immunosuppressant (eg, MTX, AZA, CSA, chlorambucil), or chloroquine, or thalidomide. Pyoderma gangrenosum (PG).Tried one systemic CS or immunosuppressant (eg, mycophenolate, CSA) for 2 mos or was intolerant to one of these agents. Hidradenitis suppurativa (HS).Tried 1 tx (eg, intralesional/oral CS, systemic antibiotic, isotretinoin).GVHD.Tried one conventional systemic treatment (eg, high-dose CS, antithymocyte globulin, CSA, thalidomide, tacrolimus, MM, etc.). JIA (regardless of type of onset) approve if pt has tried 1 other agent for this condition (eg, MTX, sulfasalazine, or leflunomide, an NSAID, or one biologic DMARD [eg, Humira, Orencia, Enbrel, Kineret, Actemra]) or the pt has aggressive disease. PP- approve if the patient has tried at least at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant or the patient has a contraindication to methotrexate (MTX), as determined by the prescriber.Note-a previous trial of a biologic also counts as a trial of a systemic agent. cont tx - approve if patient has had a response, as determined by the prescriber.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Behcet's disease (BD). Still's disease (SD). Uveitis (UV). Pyoderma gangrenosum (PG). Hidradenitis suppurativa (HS). Graft-versus-host disease (GVHD). Juvenile Idiopathic Arthritis (JIA). Sarcoidosis
<b>Part B Prerequisite</b>	No

# REPATHA

## Products Affected

- REPATHA
- REPATHA SURECLICK
- REPATHA PUSHTRONEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of Leqvio or Praluent.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
<b>Age Restrictions</b>	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
<b>Coverage Duration</b>	Approve for 1 year
<b>Other Criteria</b>	<p>Hyperlipidemia with HeFH-approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation.</p> <p>Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: history of coronary artery disease, prior MI, history of ACS, diagnosis of angina, history of CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL (55 mg/dL for members with T2DM) or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has a) tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above) OR b) has baseline LDL-C 190 or greater prior to treatment with antihyperlipidemic therapy.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RETEVMO

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Medullary Thyroid Cancer/Thyroid Cancer/Solid tumors with RET gene fusion-2 years and older, NSCLC-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has locally advanced or metastatic disease AND the tumor is RET fusion-positive. Medullary Thyroid Cancer-approve if the patient has advanced or metastatic RET-mutant disease and the disease requires treatment with systemic therapy. RET Fusion-Thyroid Cancer-approve if member has advanced or metastatic thyroid cancer with a RET gene fusion, as detected by an FDA-approved test, who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). RET Fusion-Positive Solid Tumors-Approve if member has locally advanced or metastatic solid tumors with a RET gene fusion, as detected by an FDA-approved test, that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REVCovi

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## Products Affected

- REVCovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, lab values, genetic tests (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with, an immunologist, hematologist/oncologist, or physician that specializes in ADA-SCID or related disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	ADA-SCID - approve if the patient had absent or very low (less than 1% of normal) ADA catalytic activity at baseline (i.e., prior to initiating enzyme replacement therapy) OR if the patient had molecular genetic testing confirming bi-allelic mutations in the ADA gene
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# REVLIMID

## Products Affected

- LENALIDOMIDE ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG
- *lenalidomide oral capsule 2.5 mg, 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis and previous therapies or drug regimens tried.
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Follicular lymphoma-approve if the patient is using lenalidomide (generic) in combination with rituximab or has tried at least on prior therapy. MCL - approve if the patient is using lenalidomide (brand or generic) in combination with rituximab or has tried at least two other therapies or therapeutic regimens. MZL-approve if the patient is using lenalidomide (generic) in combination with rituximab or has tried at least one other therapy or therapeutic regimen. Multiple myeloma-approve. MDS-approve if the patient meets the following: Pt has transfusion-dependent anemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REVUMENIB CITRATE

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## Products Affected

- REVUFORJ ORAL TABLET 110 MG, 160 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial: Approve if member has a diagnosis of relapsed or refractory acute leukemia AND has a lysine methyltransferase 2A gene (KMT2A) translocation as determined by an FDA approved test. Reauthorization: Member has responded positively to therapy as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REZLIDHIA

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## Products Affected

- REZLIDHIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acute myeloid leukemia-approve if the patient has relapsed or refractory disease and the patient has isocitrate dehydrogenase-1 (IDH1) mutation positive disease as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# REZUROCK

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## Products Affected

- REZUROCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	cGVHD (initial): Prescribed by or in consultation with one of the following: hematologist, oncologist, or physician experienced in the management of transplant patients.
<b>Coverage Duration</b>	cGVHD (initial, reauth): 12 months
<b>Other Criteria</b>	cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RILUZOLE

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## Products Affected

- *riluzole*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RINVOQ

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants. Concurrent use with an anti-interleukin monoclonal antibody, Concurrent use with other janus kinase inhibitors, or concurrent use with Xolair.
<b>Required Medical Information</b>	Diagnosis, For Rinvoq LQ, must have documentation showing that administration via nasogastric tube is required OR documentation of inability to swallow an intact tablet.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA/AS/Non-Radiographic Spondy/PJIA, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. AD-prescr/consult with allergist, immunologist or dermatologist. UC/CD-prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	RA/PsA/UC/AS/CD initial-approve if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AD-approve if the patient has had a 3 month trial of at least one traditional systemic therapy or has tried at least one traditional systemic therapy but was unable to tolerate a 3 month trial. Note: Examples of traditional systemic therapies include azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Non-Radiographic Axial Spondyloarthritis-approve if the patient has objective signs of inflammation defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI and patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3-month trial. PJIA-Approve if member has had an inadequate response or

<b>PA Criteria</b>	<b>Criteria Details</b>
	intolerance to one or more TNF blockers (i.e. humira, enbrel) . Continuation Therapy - Patient must have responded, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ROZLYTREK

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor AND B) The patient's tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND C) The patient meets one of the following criteria (i or ii): i. The patient has progressed on prior therapies OR ii. There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# RUBRACA

## Products Affected

- RUBRACA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer - Approve if the patient is in complete or partial response to platinum-based chemotherapy regimens. Castration-Resistant Prostate Cancer - Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has metastatic disease that is BRCA-mutation positive (germline and/or somatic) AND B) The patient meets one of the following criteria (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy AND C) The patient has been previously treated with at least one androgen receptor-directed therapy AND D) The patient meets one of the following criteria (i or ii): i. The patient has been previously treated with at least one taxane-based chemotherapy OR ii. The patient is not a candidate or is intolerant to taxane-based chemotherapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RUFINAMIDE

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial therapy-approve if rufinamide is being used for adjunctive treatment. Continuation-approve if the patient is responding to therapy
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# RYDAPT

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## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For AML, FLT3 status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML -approve if the patient is FLT3-mutation positive as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SABRIL

## Products Affected

- *vigabatrín*
- *vigadrone*
- *vigpoder*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SANDOSTATIN LAR

## Products Affected

- *octreotide,microspheres* SUSPENSION,EXTENDED REL
- SANDOSTATIN LAR DEPOT RECON 10 MG  
INTRAMUSCULAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	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.Thymoma/Thymic carcinoma-prescr/consult w/oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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). 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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma, Meningioma, Thymoma and thymic carcinoma
<b>Part B Prerequisite</b>	No

# SAPROPTERIN

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## Products Affected

- *sapropterin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Palynziq
<b>Required Medical Information</b>	Diagnosis, Phe concentration
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
<b>Coverage Duration</b>	Initial-12 weeks, Continuation-1 year
<b>Other Criteria</b>	Initial-Approve. Continuation (Note-if the patient has received less than 12 weeks of therapy or is restarting therapy with sapropterin should be reviewed under initial therapy)-Approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SCSEMBLIX

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Chronic Myeloid Leukemia (CML)-approve if the patient meets the following (A and B): A) Patient has Philadelphia chromosome-positive chronic myeloid leukemia, AND B) Patient meets one of the following (i or ii): i. The chronic myeloid leukemia is T315I-positive, OR ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia. Note: Examples of tyrosine kinase inhibitors include imatinib tablets, Bosulif (bosutinib tablets), Iclusig (ponatinib tablets), Sprycel (dasatinib tablets), and Tasigna (nilotinib capsules).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SIGNIFOR

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
<b>Coverage Duration</b>	Cushing's disease/syndrome-Initial therapy - 4 months, Continuation therapy - 1 year.
<b>Other Criteria</b>	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# SIRTURO

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## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients weighing less than 15 kg
<b>Required Medical Information</b>	Diagnosis, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an infectious diseases specialist
<b>Coverage Duration</b>	9 months
<b>Other Criteria</b>	Tuberculosis (Pulmonary)-Approve if the patient has diagnosis of pulmonary tuberculosis (TB) due to Mycobacterium tuberculosis resistant to at least rifampin and isoniazid and the requested medication is prescribed as part of a combination regimen with other anti-tuberculosis agents.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SKYCLARYS

## Products Affected

- SKYCLARYS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Severe hepatic impairment or advanced disease state
<b>Required Medical Information</b>	Genetic testing, mFARS testing, labs tests noted in clinical criteria
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist, geneticist or physician who specializes in ataxias and/or neuromuscular disorders (initial and continuation)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial approval - member must meet ALL the following criteria: 1) Member has a diagnosis of Friedreichs ataxia as established by molecular genetic testing and detection of biallelic pathogenic variants in the FXN gene, 2) Member exhibits clinical signs and symptoms of disease that are consistent with Friedreichs ataxia, 3) Member has a baseline modified Friedreich Ataxia Rating Scale (mFARS) score between 20-80, 4) Member has a B-Type natriuretic Peptide (BNP) that is less than or equal to 200 pg/mL prior to initiating therapy and will be monitored periodically during treatment, 5) Prescriber attests that member does not have a history of clinically significant left-sided heart disease and/or clinically significant cardiac disease unless cardiomyopathy is associated with Friedreichs ataxia. Re-authorization approval - member must meet all the following criteria: 1) Member shows improvement of disease state as noted by an improved Friedreichs Ataxia Rating scale (mFARS) score from baseline
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SKYRIZI

## Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/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
<b>Exclusion Criteria</b>	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
<b>Required Medical Information</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	PP- Prescribed by or in consultation with a dermatologist (initial therapy), PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD/UC-presc/consult-gastro
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	PP-Initial Therapy-The patient meets ONE of the following conditions (a or b): a) The patient has tried at least one traditional systemic agent for psoriasis (e.g., methotrexate [MTX], cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light [PUVA]) for at least 3 months, unless intolerant. NOTE: An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (e.g., an adalimumab product [Humira, Cyltezo, Hyrimoz (NDCs started with 61314-)], a certolizumab pegol product [Cimzia], an etanercept product [Enbrel, Erelzi], an infliximab product [e.g., Remicade, Inflectra, Renflexis], Cosentyx [secukinumab SC injection], Ilumya [tildrakizumab SC injection], Siliq [brodalumab SC injection], Stelara [ustekinumab SC injection], or Tremfya [guselkumab SC injection]). These patients who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional systemic agent for psoriasis)b) The patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician.Continuation Therapy - Patient must have responded, as determined by the prescriber. Psoriatic arthritis (initial)-approve.

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>Continuation-patient must have responded as determined by the prescriber. CD, initial-approve if the patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated or if the patient has tried one other conventional systemic therapy for CD (Please note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. An exception to the requirement for a trial of or contraindication to steroids or a trial of one other conventional systemic agent can be made if the patient has already tried at least one biologic other than the requested medication. A biosimilar of the requested biologic does not count. A trial of mesalamine does not count as a systemic agent for Crohn's disease.) or if the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas or if the patient had ileocolonic resection (to reduce the chance of CD recurrence). Patients must be receiving an induction dosing with Skyrizi IV within 3 month of initiating therapy with Skyrizi subcutaneous.</p> <p>Continuation-patient must have responded as determined by the prescriber. Ulcerative Colitis-Must have moderately to severely active disease and a trial of 1 conventional therapy (e.g. corticosteroids or immunosuppressants) with inadequate response or significant side effects/toxicity unless contraindicated. Must have induction within the previous 3 months prior to initiating therapy with Skyrizi subcutaneously. For reauth: must have documentation from prescriber indicating improvement in condition.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SOHONOS

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## Products Affected

- SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist or orthopedist
<b>Coverage Duration</b>	Initial: 6 months. Re-authorization: 12 months.
<b>Other Criteria</b>	Initial approval - Member meets both of the following criteria: diagnosis of fibrodysplasia ossificans progressiva (FOP) and being treated to reduce the volume of new heterotopic ossification. Re-authorization criteria - Member has experienced improvement in condition as noted by one of the following: reduction, stabilization, or slowing of the rate of annualized volume of new heterotopic ossification, reduction or improvement in the signs/symptoms or number of flare-ups compared to pre-treatment levels
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SOLARAZE

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## Products Affected

- *diclofenac sodium topical gel 3 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 6 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SOLRIAMFETOL

## Products Affected

- SUNOSI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent treatment with a monoamine oxidase inhibitor (MAOI) or use of an MAOI within the preceding 14 days
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with neurologist, pulmonologist, psychiatrist, or sleep specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial-Excessive Daytime Sleepiness-Approve if member has a diagnosis of excessive daytime sleepiness associated with narcolepsy confirmed by submitted polysomnographic evaluation (i.e sleep study) with subsequent Multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 8 minutes and two or more sleep onset rapid eye movement periods (SOREMPs) including any SOREMP on the polysomnographic evaluation from the preceding night. Must have a trial and failure of either modafinil or armodafinil. Obstructive Sleep Apnea-Approve if member has a diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea as confirmed by submitted polysomnogram evaluation (i.e sleep study). Provider must attest that underlying airway obstruction is treated (e.g. with continuous positive airway pressure (CPAP) for at least one month prior to initiating medication AND will be continued during treatment with medication. Must have a trial and failure of either modafinil or armodafinil. Reauth-must have documentation from prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SOMATULINE

## Products Affected

- SOMATULINE DEPOT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescribed by or in consultation with an endocrinologist. Carcinoid syndrome-prescribed by or in consultation with an oncologist, endocrinologist or gastroenterologist. All neuroendocrine tumors-prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescribed by or in consultation with an endo/onc/neuro.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if the patient has 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). Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptide-secreting tumors [VIPomas], insulinomas)-approve. Carcinoid Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma
<b>Part B Prerequisite</b>	No



# SOMAVERT

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## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient 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) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SPRYCEL

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# STELARA

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	18 years and older CD/UC (initial therapy). PP-6 years and older (initial therapy).
<b>Prescriber Restrictions</b>	Plaque psoriasis.Prescribed by or in consultation with a dermatologist (initial therapy). PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD/UC-prescribed by or in consultation with a gastroenterologist (initial therapy).
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	PP initial - Approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab) OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. CD, initial therapy (only after receiving single IV loading dose within 2 months of initiating therapy with Stelara SC) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.PP initial - approve Stelara SC. CD, initial therapy - approve 3 months of the SC formulation if the

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# STIVARGA

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## Products Affected

- STIVARGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For GIST, patient must have previously been treated with imatinib or Ayvakit and sunitinib or Sprycel. For HCC, patient must have previously been treated with at least one systemic regimen. Colon and Rectal cancer-approve if the patient has advanced or metastatic disease, has been previously treated with a fluoropyrimidine, oxaliplatin, irinotecan and if the patient's tumor or metastases are wild-type RAS, the patient has tried Erbitux or Vectibix.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# STRENSIQ

## Products Affected

- STRENSIQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	Disease onset-less than or equal to 18
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SUCRAID

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## Products Affected

- SUCRAID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SUTENT

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## Products Affected

- *sunitinib malate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Gastrointestinal stromal tumors (GIST), approve if the patient tried imatinib (Gleevec). Renal Cell Carcinoma (RCC), clear cell or non-clear cell histology-approve if the patient is at high risk of recurrent clear cell RCC following nephrectomy and Sutent is used for adjuvant therapy or if the patient has relapsed or Stage IV disease. Neuroendocrine tumors of the pancreas-approve for advanced or metastatic disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# SYMDEKO

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## Products Affected

- SYMDEKO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Combination therapy with Orkambi, Kalydeco or Trikafta
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve if member has diagnosis of cystic fibrosis and meets A or B: A) Must be homozygous for the F508del mutation or if the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use or B) Member has at least one mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SYMLIN

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## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# SYNAREL

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## Products Affected

- SYNAREL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Endometriosis-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Central Precocious Puberty-12 months, Endometriosis-6 months
<b>Other Criteria</b>	Central precocious puberty-approve. Endometriosis-approve if the patient has tried one of the following, unless contraindicated, a contraceptive, an oral progesterone or a depo-medroxyprogesterone injection. Note: An exception to the requirement for a trial of the above therapies can be made if the patient has previously used a gonadotropin-releasing hormone (GnRH) agonist or antagonist for endometriosis.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TABRECTA

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## Products Affected

- TABRECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is positive for a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TACROLIMUS (TOPICAL)

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## Products Affected

- *tacrolimus topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TADALAFIL

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## Products Affected

- *tadalafil oral tablet 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of nitrates.
<b>Required Medical Information</b>	Diagnosis of benign prostatic hyperplasia (BPH). Trial and failure, contraindication, or intolerance to an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAFAMIDIS

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## Products Affected

- VYNDAMAX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with Onpattro or Tegsedi. Concurrent use of Vyndaqel and Vyndamax.
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis-approve if the diagnosis was confirmed by one of the following (i, ii or iii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy), ii. Amyloid deposits are identified on cardiac biopsy OR iii. patient had genetic testing which, according to the prescriber, identified a TTR mutation AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAFINLAR

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## Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET FOR SUSPENSION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# TAGRISSE

## Products Affected

- TAGRISSE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial Criteria: Approve if the member has a diagnosis of non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, as detected by an FDA-approved test that meets one of the following criteria: 1) medication will be used as adjuvant therapy after tumor resection 2) disease is locally advanced, unresectable (stage III) and has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy 3) medication will be used as first-line treatment in member with metastatic disease OR 4) medication will be used in combination with pemetrexed and platinum-based chemotherapy as the first-line treatment of member with locally advanced or metastatic disease. EGFR T790M Mutations-Approve if the member has metastatic EGFR T790M mutation-positive NSCLC, as detected by an FDA-approved test AND disease has progressed on or after EGFR TKI therapy. Reauthorization Criteria: Approve if the member has responded positively to therapy, without disease progression or unacceptable toxicity, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TALZENNA

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## 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
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, for Breast Cancer only: BRCA mutation status, HER2 status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Recurrent or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive AND human epidermal growth factor receptor 2 (HER2) negative disease. Prostate cancer - approve if the patient has metastatic castration resistant prostate cancer, AND is using this medication concurrently with a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy AND the patient has homologous recombination repair (HRR) gene-mutated disease [Note: HRR gene mutations include ATM, ATR, BRCA1, BRCA2, CDK12, CHEK2, FANCA, MLH1, MRE11A, NBN, PALB2, or RAD51C] AND the medication is used in combination with Xtandi (enzalutamide capsules and tablets).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TARGRETIN TOPICAL

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## Products Affected

- *bexarotene topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TASIGNA

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## Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Tasigna is being used. For indication of CML, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, patient must have Ph-positive CML.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAVALISSE

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## Products Affected

- TAVALISSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Idiopathic Thrombocytopenic Purpura (ITP) (initial): Diagnosis of chronic immune ITP or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL or platelet count is between 30,000/mcL and 50,000/mcL and patient is at an increased risk of bleeding. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], splenectomy, thrombopoietin receptor agonists (e.g., Nplate, Promacta), or Rituxan (rituximab) unless a patient has had a splenectomy. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
<b>Coverage Duration</b>	ITP (initial, reauth): 12 months
<b>Other Criteria</b>	ITP (reauth): Documentation of positive clinical response to therapy by confirmation of a beneficial response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAVNEOS

## Products Affected

- TAVNEOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of one of the following types of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: a) Granulomatosis with polyangiitis (GPA) OR b) Microscopic polyangiitis (MPA). Diagnosis is confirmed by one of the following: a) ANCA test positive for proteinase 3 (PR3) antigen or PR3 antibodies, b) ANCA test positive for myeloperoxidase (MPO) antigen or MPO antibodies, c) Tissue biopsy, or d) presence of ANCA antibodies. Patient is receiving concurrent immunosuppressant therapy with one of the following: a) cyclophosphamide, b) rituximab, c) azathioprine, or d) mycophenolate mofetil. One of the following: a) Patient is concurrently on glucocorticoids (e.g., prednisone) OR b) History of contraindication or intolerance to glucocorticoids (e.g., prednisone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Tavneos). Patient is receiving concurrent immunosuppressant therapy (e.g., azathioprine, cyclophosphamide, methotrexate, rituximab, mycophenolate mofetil).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAZAROTENE

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## Products Affected

- *tazarotene topical cream 0.1 %*
- *tazarotene topical gel*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TAZVERIK

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## Products Affected

- TAZVERIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Epithelioid Sarcoma-16 years and older, Follicular Lymphoma-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Epithelioid Sarcoma-approve if the patient has metastatic or locally advanced disease and the patient is not eligible for complete resection. Follicular Lymphoma-approve if the patient has relapsed or refractory disease and according to the prescriber, there are no appropriate alternative therapies or the patient's tumor is positive for an EZH2 mutation and the patient has tried at least two prior systemic therapies.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# TEPMETKO

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## Products Affected

- TEPMETKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC-approve if the patient has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutations, as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TERIFLUNOMIDE

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## Products Affected

- TERIFLUNOMIDE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of teriflunomide with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of MS, to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TERIPARATIDE

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## Products Affected

- TERIPARATIDE SUBCUTANEOUS  
PEN INJECTOR 20 MCG/DOSE  
(620MCG/2.48ML)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has

<b>PA Criteria</b>	<b>Criteria Details</b>
	CKD or has had an osteoporotic fracture or fragility fracture. Patients who have already taken teriparatide for 2 years - approve if the patient is at high risk for fracture.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TETRABENAZINE

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## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	For treatment of chorea associated with Huntington's disease, must be prescribed by or after consultation with a neurologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# THALOMID

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## Products Affected

- THALOMID ORAL CAPSULE 100 MG,  
50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	MM - 18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TIBSOVO

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## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, IDH1 Status
<b>Age Restrictions</b>	All diagnoses - 18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test. Cholangiocarcinoma- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive and has been previously treated with at least one chemotherapy regimen (Part B before Part D Step Therapy - applies only to beneficiaries enrolled in an MA-PD plan). Myelodysplastic Syndrome-approve if patient has isocitrate dehydrogenase-1 (IDH1) mutation-positive disease AND relapsed or refractory disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TIRZEPATIDE

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## Products Affected

- ZEPBOUND SUBCUTANEOUS PEN INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other glucagon-like-peptide-1 (GLP-1) agonists or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonists
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a provider specializing in sleep medicine, endocrinology, bariatrics, cardiology, or pulmonary disease
<b>Coverage Duration</b>	Initial: 6 months Reauthorization: 12 months
<b>Other Criteria</b>	Under CMS Review.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# TOBRAMYCIN (NEBULIZATION)

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## Products Affected

- *tobramycin in 0.225 % nacl*
- *tobramycin inhalation*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CF-prescr/consult w/pulm/phys specializes in tx of CF.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Cystic fibrosis-approve if the patient has pseudomonas aeruginosa in the culture of the airway.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TOLVAPTAN

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## Products Affected

- *tolvaptan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Jynarque.
<b>Required Medical Information</b>	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 30 days
<b>Other Criteria</b>	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on tolvaptan and has received less than 30 days of therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TOPICAL RETINOID PRODUCTS

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## Products Affected

- *tretinoin topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for cosmetic use.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TRANSDERMAL FENTANYL

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Acute (i.e., non-chronic) pain.
<b>Required Medical Information</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# TREMFYA

## Products Affected

- TREMFYA PEN
- TREMFYA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with TNF-blocking or other biologic agent
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Plaque psoriasis - Prescribed by or in consultation with a dermatologist. Psoriatic Arthritis - prescribed by or in consultation with a rheumatologist or dermatologist. UC-Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For PsA: must have active disease AND must have trial of 1 conventional systemic therapy (e.g., methotrexate, leflunomide, cyclosporine, sulfasalazine) with inadequate responses or significant side effects/toxicities or have contraindication to these therapies. For plaque psoriasis: must have trial of 1 conventional systemic therapy (e.g., methotrexate, acitretin, cyclosporine) with inadequate response or significant side effects/toxicity or have a contraindication OR phototherapy or photochemotherapy with inadequate response or significant side effects/toxicity or have a contraindication. For reauth: must have documentation from prescriber indicating improvement in condition. For UC, must have moderately to severely active disease and a trial of 1 conventional therapy (e.g. corticosteroids or immunosuppressants) with inadequate response or significant side effects/toxicity unless contraindicated.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TRIENTINE

## Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, medication history of penicillimine, pregnancy status, disease manifestations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	For Wilson's Disease, approve if the patient meets A and B: A) Diagnosis of Wilson's disease is confirmed by ONE of the following (i or ii): i. Genetic testing results confirming biallelic pathogenic ATP7B mutations (in either symptomatic or asymptomatic individuals), OR ii. Confirmation of at least two of the following (a, b, c, or d): a. Presence of Kayser-Fleischer rings, OR b. Serum ceruloplasmin levels less than 20mg/dL, OR c. Liver biopsy findings consistent with Wilson's disease, OR d. 24-hour urinary copper greater than 40 micrograms/24 hours, AND B) Patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant, OR 6) the patient has been started on therapy with trientine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# TRIKAFTA

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## Products Affected

- TRIKAFTA ORAL TABLETS, SEQUENTIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
<b>Required Medical Information</b>	Diagnosis, specific CFTR gene mutations, concurrent medications
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	CF - must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TRUQAP

## Products Affected

- TRUQAP

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Breast Cancer-Approve if the patient meets the following (A, B, C, D and E): A) Patient has locally advanced or metastatic disease, AND B) Patient has hormone receptor positive (HR+) disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative disease, AND D) Patient has at least one phosphatidylinositol 3-kinase (PIK3CA), serine/threonine protein kinase (AKT1), or phosphatase and tensin homolog (PTEN)-alteration, AND E) Patient meets one of the following (i or ii): i. Patient has had progression with at least one endocrine-based regimen in the metastatic setting (Note: Examples of endocrine therapy include anastrozole, exemestane, and letrozole.) OR ii. Patient has recurrence on or within 12 months of completing adjuvant endocrine therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TUKYSA

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## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Breast Cancer-approve if the patient has advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive disease, has received at least one prior anti-HER2-based regimen in the metastatic setting and Tukysa is used in combination with trastuzumab and capecitabine. Colon/Rectal Cancer-approve if the requested medication is used in combination with trastuzumab, patient has unresectable or metastatic disease, human epidermal growth factor receptor 2 (HER2)-positive disease, Patient's tumor or metastases are wild-type RAS (KRAS wild-type and NRAS wild-type), AND Patient has been previously treated with a fluoropyrimidine, AND oxaliplatin, AND irinotecan.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TURALIO

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## Products Affected

- TURALIO ORAL CAPSULE 125 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TYSABRI

## Products Affected

- TYSABRI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agents used for MS. Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) in Crohn's disease (CD) patients.
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Adults (initial and continuation)
<b>Prescriber Restrictions</b>	MS. Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS (initial and continuation). CD. Prescribed by or in consultation with a gastroenterologist (initial and continuation).
<b>Coverage Duration</b>	MS-Authorization will be for 1 year .CD, initial-6 mo. CD, cont therapy-1 year.
<b>Other Criteria</b>	Adults with a relapsing form of MS-initial. Approve if the patient is new to therapy and has had a trial of generic dimethyl fumarate (prior treatment with Tecfidera, Bafiertam or Vumerity also counts. Also, a patient who has previously tried a glatiramer product (Copaxone, Glatopa, generic) can bypass the requirement of a trial of generic dimethyl fumarate) OR approve if the patient has highly active or aggressive multiple sclerosis by meeting one of the following: a) rapidly advancing deterioration in physical functioning Note: examples include loss of mobility/or lower levels of ambulation, severe changes in strength or coordination, b) disabling relapse with suboptimal response to systemic corticosteroids, c) magnetic resonance imaging (MRI) findings suggest highly active or aggressive multiple sclerosis Note: Examples include new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions, or d) manifestations of multiple sclerosis-related cognitive impairment OR patient has previously received one of the following therapies: Lemtrada, Ocrevus, or Kesimpta.Continuation-approve if the patient has had a response to Tysabri.Adults with CD, initial. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein) and patient has tried two of the following agents for CD for at least 2 months

<b>PA Criteria</b>	<b>Criteria Details</b>
	each: adalimumab, certolizumab pegol, infliximab, vedolizumab, ustekinumab, OR pt has had an inadequate response or was intolerant to these agents. CD, continuation therapy. Patient has had a response to Tysabri, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# TYVASO

## Products Affected

- TYVASO DPI INHALATION 16(112)-32(112) -48(28) MCG, 32 MCG, CARTRIDGE WITH INHALER 16 MCG, 48 MCG, 64 MCG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH/PAH associated with ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH/PAH associated with ILD: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. PAH (Reauth): Documentation of positive clinical response to therapy. PAH associated with Interstitial lung disease (ILD) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH AND diagnosis of ILD is confirmed by high-resolution computed tomography. PAH associated with ILD (reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# UPTRAVI

## Products Affected

- UPTRAVI ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Confirmation of right heart catheterization, medication history of current use or previous use of one of the following: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], Adempas, prostacyclin therapy (eg, Orenitram, Ventavis, or epoprostenol injection)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to therapy must meet a) OR b): a) tried one or is currently taking one oral therapy for PAH for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# VALCHLOR

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## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Cutaneous lymphoma-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Cutaneous Lymphomas (Note-includes mycosis fungoides/Sezary syndrome, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders)-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VALTOCO

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## Products Affected

- VALTOCO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VANFLYTA

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## Products Affected

- VANFLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acute Myeloid Leukemia: approve if the patient has FLT3-ITD mutation-positive disease as detected by an approved test and this medication is being used for induction, consolidation, or maintenance treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VEMLIDY

## Products Affected

- VEMLIDY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Gastroenterologist, hepatologist, transplant physician, or infectious disease physician
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Initial-Approve if member has diagnosis of chronic hepatitis B confirmed by ALL of the following: HBsAg positive or negative for at least 6 months, documented evidence of active viral replication (HBeAg+ and HBV DNA greater than 100,000 copies per mL), documented evidence of active liver disease as demonstrated by persistent elevation in serum alanine aminotransferase (ALT) greater than two times the upper limit of normal OR moderate to severe hepatitis on biopsy. Must have a trial of entecavir and tenofovir disoproxil fumarate with inadequate response or significant side effects OR have a contraindication to these therapies. Reauthorization- Approve if documentation provided indicates continued benefit from treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VENCLEXTA

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML-approve if the patient is using Venclexta in combination with either azacitidine, decitabine, or cytarabine. In addition, for all covered diagnoses (except AML), approve if the patient has tried Imbruvica prior to approval of Venclexta.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VERZENIO

## Products Affected

- VERZENIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Breast Cancer, Early-Approve if pt meets (A, B, and C): A)Pt has HR+ and HER2-negative disease, AND B) Pt has node-positive disease at high risk of recurrence (Note-High risk includes patients with greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease or tumor size greater than or equal to 5 cm C) Medication be used in combo with endocrine therapy (tamoxifen or an aromatase inhibitor). Breast Cancer, Advanced or Metastatic-Approve if pt has HR+ and HER2-negative breast cancer AND medication will be used in combo with an aromatase inhibitor as initial endocrine-based therapy (i.e. anastrozole, exemestane, or letrozole). Breast Cancer, Advanced or Metastatic (no prior chemotherapy)-Approve if pt has HR+ and HER2-negative breast cancer with disease progression following endocrine therapy AND the medication will be used in combination with fulvestrant. Breast Cancer, Advanced or Metastatic (after chemotherapy)-Approve if pt has HR+ and HER2-negative breast cancer following endocrine therapy AND prior chemotherapy in the metastatic setting AND medication will be used as monotherapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# VIBERZI

## Products Affected

- VIBERZI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Lack of gallbladder. Known or suspected biliary duct obstruction, or sphincter of Oddi disease or dysfunction. Alcoholism, alcohol abuse, alcohol addiciton, or drink more than 3 alcoholic beverages/day. History of pancreatitis, structural diseases of the pancreas, including known or suspected pancreateic duct obstruction. severe hepatic impairment. history of chronic or severe constipation or sequalae from constipation, or known or suspected mechanical gastrointestinal obstruction.
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with gastroenterologist
<b>Coverage Duration</b>	6 months (initial) 12 months (reauth)
<b>Other Criteria</b>	Diarrhea-predominant irritable bowel syndrome (IBS-D) that has persisted for 6 months or longer AND a history of failure, contraindication or intolerance to two of the following antispasmodics (e.g. dicyclomine), antidiarrheal (e.g. diphenoxylate/atropine), or tricyclic antidepressants (e.g. amitriptyline) Reauth - documentation from prescriber indicating improvement in condition
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# VIJOICE

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## Products Affected

- VIJOICE ORAL GRANULES IN PACKET
- VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, PIK3CA gene mutation
<b>Age Restrictions</b>	2 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	PIK3CA-Related Overgrowth Spectrum - patient has at least one target lesion identified on imaging
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VIMIZIM

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## Products Affected

- VIMIZIM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine-6-sulfatase activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating N-acetylgalactosamine-6-sulfatase gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VITRAKVI

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, NTRK gene fusion status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VIZIMPRO

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## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, EGFR status, exon deletions or substitutions
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NSCLC-approve if the patient has advanced or metastatic disease, has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VONJO

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## Products Affected

- VONJO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Myelofibrosis (MF), including primary MF, post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate risk or high risk disease and the patient has a platelet count of less than $50 \times 10^9/L$ (less than 50,000/mcL)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VORASIDENIB

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## Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 Months
<b>Other Criteria</b>	Initial Criteria: Member must have a grade 2 astrocytoma or oligodendroglioma with susceptible IDH1 or IDH2 mutation, as detected by an approved test, following surgery including biopsy, sub-total resection, or gross total resection with chart note documentation. Provider attests liver laboratory tests (AST, ALT, GGT, total bilirubin and ALP) have been monitored prior to the start of the requested medication and monitoring will continue every 2 weeks during the first two months of treatment, then monthly for the first 2 years of treatment. Reauthorization Criteria: Approve if the member has responded positively to therapy, without disease progression or unacceptable toxicity, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VORICONAZOLE (ORAL)

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## Products Affected

- voriconazole oral suspension for reconstitution
- voriconazole oral tablet 200 mg, 50 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VOSEVI

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## Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance
<b>Part B Prerequisite</b>	No



# VOTRIENT

## Products Affected

- *pazopanib*
- VOTRIENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma, or solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma], approve. Advanced Renal Cell Carcinoma, Clear Cell or non-Clear Cell histology-approved if the patient has relapsed or stage IV disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# VOWST

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## Products Affected

- VOWST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis. Must have documentation of a stool test positive for toxigenic <i>Clostridioides difficile</i> . Must have a trial of both bezlotoxumab and fecal microbiota, live-jslm with an inadequate response or significant side effect/toxicity or have a contraindication to these therapies.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Gastroenterologist or infectious disease specialist
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	Reauthorization is subject to all initial criteria and requires chart note documentation describing the previous response and clinical rationale for retreatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	Yes

# VUMERITY

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## Products Affected

- VUMERITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Approve if the patient is new to therapy and if the patient has tried a generic MS disease modifying agent. Note: Prior use of brand Tecfidera, Bafiertam, Aubagio with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# WEGOVY

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial-6 months Reauth-12 months
Other Criteria	Initial-Must be used in combination with a reduced calorie diet and increased physical activity to reduce the risk of major adverse cardiovascular (CV) events in members with established CV disease. Must be either obese or overweight defined as having a BMI greater than or equal to 27 kg per m2 upon initial request. Chart note documentation must include baseline body weight and calculated BMI. Must have established CV disease defined by one of the following: previous myocardial infarction, ischemic or hemorrhagic stroke, or symptomatic peripheral arterial disease (PAD). Provider must attest the member has a plan for reduced-calorie diet and increased physical activity and has been evaluated for co-morbid conditions that increase the risk of CV disease. Provider must indicate if the member has one of the following: dyslipidemia, heart failure (HF), chronic kidney disease (CKD), or type 2 diabetes mellitus (T2DM) and provide attestation that members with co-morbidities will be treated (as determined by the prescriber). Must provide clinical rationale for use of semaglutide (Wegovy) instead of semaglutide (Ozempic) that includes why semaglutide (Ozempic) is not producing a sufficient risk reduction and why semaglutide (Wegovy), the same chemical, is expected to produce a better risk reduction. Reauth-Approve if the member has responded positively to therapy as determined by the prescribing physician, the member continues to follow the plan for reduced-calorie diet and

<b>PA Criteria</b>	<b>Criteria Details</b>
	increased physical activity, and attestation that members with co-morbidities will continue to be treated as determined by the prescriber
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# WELIREG

## Products Affected

- WELIREG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renal Cell Carcinoma- approve if pt has advanced disease AND has tried at least one programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor AND has tried at least one a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI). Van Hippel-Lindau Disease-approve if the patient meets the following (A, B, and C): A) Patient has a von Hippel-Lindau (VHL) germline alteration as detected by genetic testing, B) Does not require immediate surgery and C) Patient requires therapy for ONE of the following conditions (i, ii, iii, or iv): i. Central nervous system hemangioblastomas, OR ii. Pancreatic neuroendocrine tumors, OR iii. Renal cell carcinoma, OR iv. Retinal hemangioblastoma.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# WINREVAIR

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Platelet and hemoglobin counts prior to initiating therapy, PAH WHO group, right heart catheterization results
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a clinician with expertise in treating patients with pulmonary arterial hypertension
<b>Coverage Duration</b>	6 months (initial), 12 months (continuation)
<b>Other Criteria</b>	Initial: Member must have a diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1. Diagnosis has been confirmed with hemodynamic definitions obtained from a right heart catheterization (RHC) and chart notes documenting the following a, b, and c: a) mean arterial pressure (mPAP) measured greater than or equal to 20mmHg at rest b) pulmonary artery wedge pressure (PAWP) measured less than or equal to 15 mmHg c) pulmonary vascular resistance (PVR) greater than or equal to 2 woods units. Member must be established, have a contraindication, or an intolerance to at least two medications from the following drug classes: Phosphodiesterase Type-5 Inhibitor, Endothelin Receptor Antagonist, Soluble cGMP Stimulator, or Prostacyclin Receptor Agonist. Must have baseline negative pregnancy test prior to initiation of therapy if a natal female of reproductive potential and platelet counts are greater than 50,000/mm <sup>3</sup> prior to initiation of therapy and will be discontinued if dropped to less than 50,000/mm <sup>3</sup> . Reauthorization: Approve if the patient has responded to therapy as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XALKORI

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## Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dignosis
<b>Age Restrictions</b>	Anaplastic large cell lymphoma-patients greater than or equal to 1 year of age. Inflammatory Myofibroblastic Tumor - 1 year of age and older. All other diagnoses -18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Metastatic non-small cell lung cancer-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease, as detected by an approved test or ROS1 rearrangement positive disease, as detected by an approved test. Anaplastic Large Cell Lymphoma-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease AND has received at least one prior systemic treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# XDEMVY

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## Products Affected

- XDEMVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 weeks
<b>Other Criteria</b>	Approve if the member has a diagnosis of blepharitis due to Demodex infestation confirmed by the presence of all the following in at least one (1) eye: 1) Demodex infestations with greater than 10 lashes with collarettes present on the upper lid (collarette scale grade 2 or worse), 2) mild erythema of the upper eyelid margin, 3) average mite density of greater than 1.5 mites per lash (upper and lower eyelids combined).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XELJANZ

## Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ XR
- XELJANZ ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a biologic or with a Targeted Synthetic DMARD for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	AS/PsA/RA/UC-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	RA, JIA/JRA/AS-prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	RA initial-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. PsA initial, approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial and the requested medication will be used in combination with methotrexate or another conventional synthetic disease modifying antirheumatic drug (DMARD), unless contraindicated. UC- Approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least ONE tumor necrosis factor inhibitor for ulcerative colitis or was unable to tolerate a 3-month trial. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthritis/active sacroiliac arthritis]-initial-approve Xeljanz immediate release tablets or solution if the patient meets the following: patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AS-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least

<b>PA Criteria</b>	<b>Criteria Details</b>
	one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XERMELO

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## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]) AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XIAFLEX

## Products Affected

- XIAFLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Retreatment (i.e., treatment beyond three injections per affected cord for those with Dupuytren's Contracture or beyond eight injections for Peyronie's Disease).
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Dupuytren's Contracture-administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture. Peyronie's Disease -administered by a healthcare provider experienced in the treatment of male urological diseases.
<b>Coverage Duration</b>	Dupuytren's Contracture-3 months, Peyronie's Disease-6 months
<b>Other Criteria</b>	Dupuytren's Contracture-at baseline (prior to initial injection of Xiaflex), the patient had contracture of a metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint of at least 20 degrees AND the patient will not be treated with more than a total of three injections (maximum) per affected cord. Peyronie's Disease-the patient meets ONE of the following (i or ii): i. at baseline (prior to use of Xiaflex), the patient has a penile curvature deformity of at least 30 degrees OR in a patient who has received prior treatment with Xiaflex, the patient has a penile curvature deformity of at least 15 degrees AND the patient has not previously been treated with a complete course (8 injections) of Xiaflex for Peyronie's disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XIFAXAN

## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Travelers Diarrhea complicated by fever or blood in stool or diarrhea due to pathogens other than Escherichia coli.
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Traveler's Diarrhea and IBS-D-14 days. Hepatic Encephalopathy-12 months
<b>Other Criteria</b>	Travelers Diarrhea (TD)-Approve if provider attest member's diagnosis has not been complicated by fever nor bloody stools AND TD is caused by non-invasive strains of E. coli. Member must have previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, or azithromycin. Initial-Irritable bowel syndrome with diarrhea (IBS-D)- Approve if member has diagnosis of diarrhea-predominant irritable bowel syndrome (IBS-D). Must have previous treatment, intolerance or contraindication of loperamide AND antispasmodic (e.g. dicyclomine) with inadequate response to these therapies. Must have chart note documentation on how the diagnosis was confirmed. Reauthorization-IBS-D-Must have chart note documentation indicating recurrence. Recurrence must not have been treated more than twice with the the same regimen. Initial-Hepatic encephalopathy (HE)-Approve if member has diagnosis of HE. Must have previous treatment, intolerance or contraindication of lactulose. Reauthorization-HE-Provider attests the member has benefitted from the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# XOLAIR

## 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
<b>Exclusion Criteria</b>	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody or Palforzia (peanut allergen powder)
<b>Required Medical Information</b>	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). CIU - must have urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).
<b>Age Restrictions</b>	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older.
<b>Prescriber Restrictions</b>	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist. Polyps-prescribed by or in consult with an allergist, immunologist, or otolaryngologist. Food allergy- allergist or immunologist
<b>Coverage Duration</b>	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months, Food allergy-1 yr
<b>Other Criteria</b>	Initial-Moderate to severe persistent asthma-Approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The



<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80 percent predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - must have responded to therapy as determined by the prescribing physician. Nasal Polyps Initial-Approve if the patient has a baseline IgE level greater than or equal to 30 IU/ml, patient is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell and patient is currently receiving therapy with an intranasal corticosteroid. Nasal polyps continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid and has responded to therapy. IgE-Mediated Food Allergy-approve if pt meets (A, B, C and D): (A) baseline IgE greater than or equal to 30 IU/mL, and (B) positive skin prick test to one or more foods and positive in vitro test for IgE to one or more foods, and (C) history of allergic reaction that met all of the following: pt demonstrated signs and symptoms of a significant systemic allergic reaction, and reaction occurred within a short period of time following a known ingestion of the food, and prescriber deemed this reaction significant enough to require a prescription for an epinephrine auto-injector, and (D) pt has been prescribed an epinephrine auto-injector.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XOSPATA

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## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, FLT3-mutation status
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XPOVIO

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Multiple Myeloma-Approve if the patient meets the following (A and B): A) The medication will be taken in combination with dexamethasone AND B) Patient meets one of the following (i, ii, or iii): i. Patient has tried at least four prior regimens for multiple myeloma OR ii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with bortezomib. Diffuse large B-cell lymphoma-approve if the patient has been treated with at least two prior systemic therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

# XTANDI

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Xtandi is being used.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Prostate cancer-castration-resistant [Metastatic or Non-metastatic] and Prostate cancer-metastatic, castration sensitive-approve if Xtandi will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy. Prostate cancer- Non-Metastatic, Castration-Sensitive - approve if pt has biochemical recurrence and is at high risk for metastasis. [Note: High-risk biochemical recurrence is defined as prostate-specific antigen (PSA) doubling time less than or equal to 9 months.]
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XYREM

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## Products Affected

- SODIUM OXYBATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Xywav, Wakix, Sunosi
<b>Required Medical Information</b>	Medication history of CNS stimulant (e.g., methylphenidate, dextroamphetamine), modafinil, or armodafinil
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by a sleep specialist physician or a Neurologist
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dextroamphetamine), modafinil, or armodafinil (for members 18 years of age and older only) and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# XYWAV

## Products Affected

- XYWAV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of sedatives, concomitant use of alcohol, succinic semialdehyde dehydrogenase deficiency
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with neurologist, psychiatrist, or sleep specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>Initial-Narcolepsy with Cataplexy-Approve if member has a diagnosis of narcolepsy with cataplexy confirmed by submitted polysomnographic evaluation (i.e sleep study) with subsequent Multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 8 minutes and two or more sleep onset rapid eye movement periods (SOREMPs) including any SOREMP on the polysomnographic evaluation from the preceding night. Must provide history of cataplexy episodes. Must have a trial and failure of sodium oxybate. Excessive Daytime Sleepiness-Approve if member has a diagnosis of excessive daytime sleepiness associated with narcolepsy confirmed by submitted polysomnographic evaluation (i.e sleep study) with subsequent Multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 8 minutes and two or more sleep onset rapid eye movement periods (SOREMPs) including any SOREMP on the polysomnographic evaluation from the preceding night. Must have a trial and failure of solriamfetol (Sunosi) AND pitolisant (Wakix), unless both of these therapies are not FDA-approved or compendia supported for use in the member's age. Must provide baseline Epworth Sleepiness Scale (ESS). Idiopathic Hypersomnia-Approve if member has a diagnosis of idiopathic hypersomnia as confirmed by using ICSD-3 criteria with submitted polysomnography and MSLT showing: member has less than 2 sleep onset rapid eye movement periods (SOREMPs) OR has no SOREMPs if the REM sleep latency on the preceding nocturnal polysomnogram (PSG) was</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	less than or equal to 15 minutes, mean sleep latency of less than or equal to 8 minutes OR total 24-hour sleep time greater than or equal to 660 minutes (typically 12 to 14 hours) on 24-hour polysomnography monitoring or by wrist actigraphy in association with a sleep log, insufficient sleep syndrome has been ruled out, and the hypersomnolence and/or MSLT findings are not better explained by another sleep disorder, other medical or psychiatric disorder, or use of drugs or medications. Must provide baseline Epworth Sleepiness Scale (ESS) that is greater than or equal to 10. Must have absence of cataplexy. Reauthorization (all conditions)-Must have documentation from prescriber indicating improvement in condition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# YONSA

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## Products Affected

- YONSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, concomitant medications
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone and the patient meets ONE of the following criteria (i or ii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ZARXIO

## Products Affected

- ZARXIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cancer/AML, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN - hematologist.
<b>Coverage Duration</b>	chemo/SCN/AML-6mo.MDS-3mo.PBPC,BMT- 3mo. Other-12mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# ZEJULA

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - approve if the patient is in complete or partial response after first-line platinum-based chemotherapy regimen. Deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - - approve if the patient is in complete or partial response after first-line platinum-based chemotherapy regimen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZELBORAF

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## Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	BRAFV600 mutation status required.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresectable, advanced or metastatic melanoma. Erdheim-Chester disease, in patients with the BRAF V600 mutation-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZEPOSIA

## Products Affected

- ZEPOSIA
- ZEPOSIA STARTER KIT (28-DAY)
- ZEPOSIA STARTER PACK (7-DAY)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	MS-Concurrent use with other disease-modifying agents used for multiple sclerosis. UC- Concurrent Use with a Biologic or with a Targeted Synthetic Disease-modifying Antirheumatic Drug (DMARD) for Ulcerative Colitis
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	UC-18 years and older
<b>Prescriber Restrictions</b>	MS-Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis. UC-Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	MS, initial treatment-approve if the patient has tried generic dimethyl fumarate. Note: Prior use of brand Tecfidera, Bafiertam or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts. Ulcerative Colitis, initial-approve if the patient has tried an adalimumab product (a trial of Simponi SC or infliximab would also count). Cont tx-approve if the patient has been established on Zeposia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZIEXTENZO

## Products Affected

- ZIEXTENZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	Cancer pts receiving chemo-6 mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if-the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZOLINZA

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## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZTALMY

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## Products Affected

- ZTALMY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant therapy with strong CYP450 inducers
<b>Required Medical Information</b>	Genetic tests for cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist
<b>Coverage Duration</b>	Initial: 6 months. Re-authorization: 12 months.
<b>Other Criteria</b>	Initial Approval-Member must meet ALL of the following: 1) diagnosis of CDD confirmed by genetic testing, 2) member must be refractory to at least TWO antiepileptic drugs, 3) member will be monitored for the emergence or worsening of depression, suicidal thoughts/behavior, unusual changes in mood or behavior. Re-Authorization approval-member must meet ALL of the following: 1) Member must meet initial criteria, 2) Member must have demonstrated a positive clinical response to Ztalmy therapy, 3) member must be absent of unacceptable toxicity from therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No



# ZURZUVAE

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## Products Affected

- ZURZUVAE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Previous treatment with Zurzuvae during the current episode of postpartum depression
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a psychiatrist or an obstetrician-gynecologist
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	Postpartum depression-approve if the patient meets the following (A, B and C): A.Patient meets BOTH of the following (i and ii): i. Patient has been diagnosed with severe depression, AND ii. Symptom onset began during the third trimester of pregnancy or up to 4 weeks post-delivery, AND B. Patient is less than or equal to 12 months postpartum, AND C. Patient is not currently pregnant.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZYDELIG

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## Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For all covered diagnoses-approve if the patient has tried Imbruvica prior to approval of Zydelig.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZYKADIA

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## Products Affected

- ZYKADIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

# ZYTIGA

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## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC)-Approve if abiraterone is being used in combination with prednisone or dexamethasone and the medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, or the medication is concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate cancer-metastatic, castration-sensitive (mCSPC)-approve if the medication is used in combination with prednisone and the medication is concurrently used with a gonadotropin-releasing hormone agonist or concurrently used with Firmagon or the patient has had a bilateral orchiectomy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Part B Prerequisite</b>	No

## PART B VERSUS PART D

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### Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- ABRAXANE INTRAVENOUS SUSPENSION FOR RECONSTITUTION 100 MG
- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- ADCETRIS INTRAVENOUS RECON SOLN 50 MG
- *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, 5 mg/ml*
- ALIMTA INTRAVENOUS RECON SOLN 100 MG, 500 MG
- ALIQOPA INTRAVENOUS RECON SOLN 60 MG
- *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*
- *arsenic trioxide intravenous solution 1 mg/ml, 2 mg/ml*
- *azacitidine injection recon soln 100 mg*
- *azathioprine oral tablet 50 mg*
- *azathioprine sodium injection recon soln 100 mg*
- BAVENCIO INTRAVENOUS SOLUTION 20 MG/ML
- BELEODAQ INTRAVENOUS RECON SOLN 500 MG
- BENDEKA INTRAVENOUS SOLUTION 25 MG/ML
- BESPONSА INTRAVENOUS RECON SOLN 0.9 MG (0.25 MG/ML INITIAL)
- BORTEZOMIB INJECTION RECON SOLN 1 MG, 2.5 MG
- *bortezomib injection recon soln 3.5 mg*
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- *busulfan intravenous solution 60 mg/10 ml*
- *carboplatin intravenous solution 10 mg/ml*
- *carmustine intravenous recon soln 100 mg*
- *cisplatin intravenous solution 1 mg/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 %
- CLINIMIX 6%-D5W (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 6-5 %
- CLINIMIX 8%-D10W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-10 %
- CLINIMIX 8%-D14W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-14 %
- *clofarabine intravenous solution 1 mg/ml*
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*
- *cyclophosphamide intravenous recon soln 1 gram, 2 gram, 500 mg*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- CYCLOPHOSPHAMIDE ORAL TABLET 25 MG, 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*
- *dacarbazine intravenous recon soln 100 mg, 200 mg*
- *dactinomycin intravenous recon soln 0.5 mg*
- **DARZALEX INTRAVENOUS SOLUTION 20 MG/ML**
- *daunorubicin intravenous solution 5 mg/ml*
- *decitabine intravenous recon soln 50 mg*
- *dexrazoxane hcl intravenous recon soln 250 mg, 500 mg*
- *docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*
- *doxorubicin intravenous recon soln 10 mg, 50 mg*
- *doxorubicin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml*
- *doxorubicin, peg-liposomal intravenous suspension 2 mg/ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- **EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ML FINAL CONC.)**
- **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**
- **ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG**
- *epirubicin intravenous solution 200 mg/100 ml*
- **ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML**
- **ERWINASE INJECTION RECON SOLN 10,000 UNIT**
- **ETOPOPHOS INTRAVENOUS RECON SOLN 100 MG**
- *etoposide intravenous solution 20 mg/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**
- *fludarabine intravenous recon soln 50 mg*
- *fludarabine intravenous solution 50 mg/2 ml*
- **FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML (1 ML), 40 MG/2 ML (20 MG/ML)**
- *formoterol fumarate inhalation solution for nebulization 20 mcg/2 ml*
- *fulvestrant intramuscular syringe 250 mg/5 ml*
- **GAZYVA INTRAVENOUS SOLUTION 1,000 MG/40 ML**
- *gemcitabine intravenous recon soln 1 gram, 2 gram, 200 mg*
- *gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)*
- **GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML**
- *gengraf oral capsule 100 mg, 25 mg*
- *gengraf oral solution 100 mg/ml*
- *granisetron hcl oral tablet 1 mg*
- **HALAVEN INTRAVENOUS SOLUTION 1 MG/2 ML (0.5 MG/ML)**
- **HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML**
- *idarubicin intravenous solution 1 mg/ml*
- *ifosfamide intravenous recon soln 1 gram, 3 gram*
- *ifosfamide intravenous solution 1 gram/20 ml, 3 gram/60 ml*
- **IMFINZI INTRAVENOUS SOLUTION 50 MG/ML**
- *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*
- *irinotecan intravenous solution 100 mg/5 ml, 300 mg/15 ml, 40 mg/2 ml, 500 mg/25 ml*
- ISTODAX INTRAVENOUS RECON SOLN 10 MG/2 ML
- IXEMPRA INTRAVENOUS RECON SOLN 15 MG, 45 MG
- JEVTANA INTRAVENOUS SOLUTION 10 MG/ML (FIRST DILUTION)
- JYLAMVO ORAL SOLUTION 2 MG/ML
- KHAPZORY INTRAVENOUS RECON SOLN 175 MG
- KYPROLIS INTRAVENOUS RECON SOLN 10 MG, 30 MG, 60 MG
- *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*
- *levoleucovorin calcium intravenous recon soln 50 mg*
- *levoleucovorin calcium intravenous solution 10 mg/ml*
- *melfhalan hcl intravenous recon soln 50 mg*
- *mesna intravenous solution 100 mg/ml*
- *methotrexate sodium (pf) injection recon soln 1 gram*
- *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*
- *mitomycin intravenous recon soln 20 mg, 40 mg, 5 mg*
- *mitoxantrone intravenous concentrate 2 mg/ml*
- MONJUVI INTRAVENOUS RECON SOLN 200 MG
- MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2 ML (20 MG/ML)
- *mycophenolate mofetil (hcl) intravenous recon soln 500 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*
- MYLOTARG INTRAVENOUS RECON SOLN 4.5 MG (1 MG/ML INITIAL CONC)
- *nelarabine intravenous solution 250 mg/50 ml*
- NULOJIX INTRAVENOUS RECON SOLN 250 MG
- ONCASPAR INJECTION SOLUTION 750 UNIT/ML
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 4 mg, 8 mg*
- *ondansetron oral tablet, disintegrating 4 mg, 8 mg*
- ONIVYDE INTRAVENOUS DISPERSION 4.3 MG/ML
- *oxaliplatin intravenous recon soln 100 mg, 50 mg*
- *oxaliplatin intravenous solution 100 mg/20 ml, 200 mg/40 ml, 50 mg/10 ml (5 mg/ml)*
- *paclitaxel intravenous concentrate 6 mg/ml*
- *paraplatin intravenous solution 10 mg/ml*
- *pentamidine inhalation recon soln 300 mg*
- PERJETA INTRAVENOUS SOLUTION 420 MG/14 ML (30 MG/ML)
- PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %
- *premasol 10 % intravenous parenteral solution 10 %*
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG
- PULMOZYME INHALATION SOLUTION 1 MG/ML

- 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
- *romidepsin intravenous recon soln 10 mg/2 ml*
- SIMULECT INTRAVENOUS RECON SOLN 10 MG, 20 MG
- *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*
- TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML), 840 MG/14 ML (60 MG/ML)
- TEMODAR INTRAVENOUS RECON SOLN 100 MG
- *temsirolimus intravenous recon soln 30 mg/3 ml (10 mg/ml) (first)*
- *thiotepa injection recon soln 100 mg, 15 mg*
- TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION 50 MG
- *topotecan intravenous recon soln 4 mg*
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- TREANDA INTRAVENOUS RECON SOLN 100 MG, 25 MG
- TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- UNITUXIN INTRAVENOUS SOLUTION 3.5 MG/ML
- *valrubicin intravesical solution 40 mg/ml*
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- YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML
- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML), 200 MG/8 ML (25 MG/ML)
- ZANOSAR INTRAVENOUS RECON SOLN 1 GRAM
- ZIRABEV INTRAVENOUS SOLUTION 25 MG/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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