KelseyCare Advantage

2027

PRIOR AUTHORIZATION CRITERIA

1-866-535-8343 (TTY:711)

www.kelseycareadvantage.com

H0332_PA27_C

ACTIMMUNE (S)

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADALIMUMAB-AATY (S)

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADALIMUMAB-ADBM (S)

Products Affected

- Adalimumab-adbm

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADALIMUMAB-FKJP (S)

Products Affected

- Adalimumab-fkjp

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADBRY (S)

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADCIRCA (S)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADEMPAS (S)

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, CTEPH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AFINITOR (S)

Products Affected

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

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

AFINITOR DISPERZ (S)

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older. TSC-associated partial-onset seizures: Patient is 2 years of age or older.
Prescriber Restrictions	TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AIMOVIG (S)

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AKEEGA (S)

Products Affected

- Akeega

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

ALECENSA (S)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALPHA-1 PROTEINASE INHIBITOR, PROLASTIN (S)

Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry), unless the patient has a concomitant diagnosis of necrotizing panniculitis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	AAT deficiency (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Continued conventional treatment for emphysema (e.g., bronchodilators).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALUNBRIG (S)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AMPYRA (S)

Products Affected

- Dalfampridine Er

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

ARFORMOTEROL (S)

Products Affected

- Arformoterol Tartrate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of COPD. Used for maintenance treatment of bronchoconstriction in patients with COPD, including chronic bronchitis and emphysema.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD: 12 months.
Other Criteria	Subject to Part B vs. Part D review.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARIKAYCE (S)

Products Affected

- Arikayce

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

AUGTYRO (S)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced, or b) metastatic. Disease is confirmed by the presence of ROS1 rearrangement positive tumor(s) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Solid Tumors: Diagnosis of solid tumors. Disease is confirmed by the presence of neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease is one of the following: a) Locally advanced, b) Metastatic, or c) Unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: a) Disease has progressed following previous treatment (e.g., radiation therapy, systemic therapy, tyrosine kinase inhibitor [TKI]), or b) Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months.
Other Criteria	All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AUSTEDO (S)

Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated with Huntington's disease. Tardive dyskinesia (initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.
Age Restrictions	N/A
Prescriber Restrictions	Huntington's disease chorea (initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AVMAPKI FAKZYNJA (S)

Products Affected

- Avmapki Fakzynja Co-pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC). Presence of a KRAS-mutation as detected by a Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVTOZMA SC (S)

Products Affected

- Avtozma INJ 162MG/0.9ML

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

AYVAKIT (S)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. Disease is one of the following: unresectable or metastatic. Presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations, as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Advanced Systemic Mastocytosis (AdvSM): Diagnosis of AdvSM. Patient has one of the following: a) aggressive systemic mastocytosis (ASM), b) systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or c) mast cell leukemia (MCL). Platelet count is greater than or equal to 50 x 10^9/L. Ayvakit 25 mg - Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than or equal to 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BALVERSA (S)

Products Affected

- Balversa

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

BENLYSTA (S)

Products Affected

- Benlysta INJ 200MG/ML

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

BESREMI (S)

Products Affected

- Besremi
- Besremi Pen

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

BOSULIF (S)

Products Affected

- Bosulif CAPS
- Bosulif TABS 100MG, 500MG
- Bosutinib TABS 400MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous/myeloid leukemia (CML): Diagnosis of Philadelphia chromosome-positive (Ph+) CML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRAFTOVI (S)

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Presence of BRAF V600E or V600K mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib). Colorectal Cancer: One of the following diagnoses: Colon Cancer or Rectal Cancer. One of the following: 1) Unresectable or advanced disease or 2) Metastatic disease. Presence of BRAF V600E mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following a) Used in combination with Erbitux (cetuximab) AND b) One of the following: i) Patient has received prior therapy OR ii) Used in combination with fluorouracil-based chemotherapy (e.g., mFOLFOX6, FOLFIRI). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Presence of BRAF V600E mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIVIACT (S)

Products Affected

- Brivaracetam SOLN
- Brivaracetam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Partial-onset seizures: Diagnosis of partial-onset seizures.
Age Restrictions	Patient is 1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRUKINSA (S)

Products Affected

- Brukinsa TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Paid claims or submission of medical records confirming patient has received at least one prior therapy for MCL [e.g., Calquence (acalabrutinib)]. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed or refractory. Paid claims or submission of medical records confirming patient has received at least one prior anti-CD20-based regimen for MZL (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of ONE of the following: CLL or SLL. Submission of medical records confirming patient has a contraindication or intolerance to Calquence (acalabrutinib). Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Paid claims or submission of medical records confirming patient has received at least two prior lines of systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BYLVAY (S)

Products Affected

- Bylvay
- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Progressive familial intrahepatic cholestasis (PFIC) (initial): Diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3, confirmed by one of the following: 1) Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis) or 2) Genetic testing. Alagille syndrome (ALGS) (initial): Both of the following: 1) Diagnosis of ALGS, and 2) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene.
Age Restrictions	PFIC (initial): Patient is 3 months of age or older. ALGS (initial): Patient is 12 months of age or older.
Prescriber Restrictions	PFIC, ALGS (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	PFIC, ALGS (initial): 12 months. PFIC, ALGS (reauth): 12 months.
Other Criteria	PFIC (reauth): Patient demonstrates positive clinical response to therapy. ALGS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CABLIVI (S)

Products Affected

- Cablivi

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

CABOMETYX (S)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate). Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease or patient is refractory to radioactive iodine treatment or ineligible. Neuroendocrine Tumors: Diagnosis of one of the following: 1) Pancreatic neuroendocrine tumors (pNET) or 2) Extra-pancreatic neuroendocrine tumors (epNET). Disease is one of the following: 1) Unresectable, 2) Locally advanced, or 3) Metastatic. Tumors are well-differentiated. Patient has been previously treated (e.g., octreotide, lanreotide, chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CALQUENCE (S)

Products Affected

- Calquence TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL). One of the following: A) All of the following: 1) Patient has received no prior therapy for MCL (e.g., bortezomib, rituximab), 2) Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) Used in combination with bendamustine and rituximab, OR B) Patient has received at least one prior therapy for MCL (e.g., bortezomib, rituximab). Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPLYTA (S)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: asenapine, aripiprazole, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, ziprasidone. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate. Trial and failure, contraindication, or intolerance to quetiapine (IR or ER) or olanzapine. Major depressive disorder (MDD): Diagnosis of MDD. Used as adjunctive therapy with an antidepressant (e.g., escitalopram, sertraline, venlafaxine/desvenlafaxine, etc.). Trial and failure, contraindication, or intolerance to both of the following oral generic formulary atypical antipsychotic agents: aripiprazole and quetiapine IR/ER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPRELSA (S)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of one of the following: a) metastatic medullary thyroid cancer (MTC) or b) unresectable locally advanced MTC. Patient has symptomatic disease or progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CAYSTON (S)

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF. Submission of medical records (e.g., chart notes, laboratory values) confirming Pseudomonas aeruginosa in the lungs.
Age Restrictions	CF (Initial): 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	CF (Initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CHOLBAM (S)

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis. Peroxisomal disorders (PD) (initial): Diagnosis of a peroxisomal disorder, including Zellweger spectrum disorders, based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry, or b) molecular genetic testing consistent with the diagnosis. Patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), b) steatorrhea, or c) complications from decreased fat-soluble vitamin absorption (eg, poor growth). Will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, gastroenterologist, or other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses (initial): 4 months, (reauth) 12 months.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement in liver function.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CIALIS (S)

Products Affected

- Tadalafil TABS 2.5MG, 5MG

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

CICLOPIROX (S)

Products Affected

- Ciclopirox Nail Lacquer

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All of the following: 1) Patient does not have lunula (matrix) involvement, 2) one of the following: a) Diagnosis of onychomycosis of the toenails, OR b) Diagnosis of onychomycosis of the fingernails, 3) Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, 4) If toenail onychomycosis, patient has mild to moderate disease involving at least 1 target toenail, AND 5) One of the following: a) For onychomycosis of fingernails, Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine, or b) For onychomycosis of toenails, trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CINRYZE (S)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by one of the following: 1) Both of the following: a) C4 level and b) One of the following: i) C1-INH antigenic level or ii) C1-INH functional level, 2) Genetic testing, or 3) Family history. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COBENFY (S)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

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

COMETRIQ (S)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COPIKTRA (S)

Products Affected

- Copiktra

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

COSENTYX (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation. Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months

Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COTELLIC (S)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Presence of BRAF V600E or V600K mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm. Used as monotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRESEMBA ORAL (S)

Products Affected

- Cresemba CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fungal infection: Diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CTEXLI (S)

Products Affected

- Ctexli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease). Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: a) Neurologist, b) Geneticist, c) Metabolic disease specialist, or d) Endocrinologist.
Coverage Duration	Initial: 12 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CYCLOBENZAPRINE (S)

Products Affected

- Cyclobenzaprine Hydrochloride TABS 10MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient. Muscle spasm: Diagnosis of muscle spasm associated with acute, painful musculoskeletal conditions. Fibromyalgia (off-label): Used to treat fibromyalgia related symptoms (e.g., difficulty sleeping). Acute temporomandibular disorder (off-label): All of the following: a) Diagnosis of acute temporomandibular disorder, b) Patient has pain on palpitation of the lower jaw muscle, and c) Used in combination with a nonsteroidal anti-inflammatory drug (NSAID) (e.g., naproxen).
Age Restrictions	PA applies to patients 65 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Muscle spasm, temporomandibular disorder: 4 weeks. Fibromyalgia: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DALIRESP (S)

Products Affected

- Roflumilast

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

DANZITEN (S)

Products Affected

- Danziten

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DARAPRIM (S)

Products Affected

- Pyrimethamine TABS

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

DAURISMO (S)

Products Affected

- Daurismo

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

DEFERASIROX (S)

Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.
Age Restrictions	Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
Other Criteria	Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DEMSER (S)

Products Affected

- Metyrosine

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

Other Criteria	Pheochromocytoma tx (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased frequency and severity of hypertensive attacks).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DIACOMIT (S)

Products Affected

- Diacomit

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

DOPTELET (S)

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Patient has chronic liver disease and is scheduled to undergo a procedure. Immune Thrombocytopenia (ITP) (initial): Dx of chronic ITP, relapsed/refractory ITP, or pediatric patient with persistent ITP. Trial and failure, contraindication, or intolerance to one previous ITP treatment (e.g., corticosteroids, (e.g., prednisone, methylprednisolone) or immunoglobulins [e.g., Gammagard, immune globulin (human)], splenectomy).
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist, oncologist, hepatologist or surgeon.
Coverage Duration	TPPP: 1 month. ITP (initial, reauth): 12 months.
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DULERA (S)

Products Affected

- Dulera

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

DUPIXENT (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Pt is currently dependent on oral CS for the treatment of asthma. EA, CDA (init): Symptoms are inadequately controlled with inhaled corticosteroids (e.g., fluticasone propionate, Wixela Inhub [fluticasone propionate/salmeterol], etc). Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Dx of CRSwNP. Unless contraindicated, the pt has had an inadequate response to 2 mo of tx with an intranasal CS (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP.
Age Restrictions	N/A
Prescriber Restrictions	AD, PN, CSU, BP (Init): Prescribed/consult with a dermatologist or allergist/immunologist. Asthma (init): Prescribed/consult with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed/consult with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (init): Prescribed/consult with a gastroenterologist or allergist/immunologist. AFRS (init): Prescribed/consult with an otolaryngologist, allergist/immunologist, or pulmonologist.
Coverage Duration	AFRS, CRSwNP, EoE (Init/Reauth): 12 mo. Asthma, AD, PN, COPD, CSU, BP (Init): 6 mo, (reauth): 12 mo.

Other Criteria	Eosinophilic esophagitis (EoE) (init): Dx of EoE. Trial and failure, contraindication, or intolerance (TF/C/I) to at least an 8-wk trial of 1 of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) CS (eg, budesonide, fluticasone). PN (init): Dx of PN. Atopic dermatitis (AD) (init): Dx of mod to severe AD. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Pt is receiving 1 of the following at maximally tolerated doses: triple therapy [ie, an ICS, a LAMA, and a LABA] OR if CI to ICS, a LAMA and a LABA. Bullous Pemphigoid (BP) (init): Dx of BP as confirmed by skin biopsy or serology. Will be used in combo w/ a tapering course of oral CS until disease control has occurred. AD (reauth): Pt demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. AFRS, EA, CDA, PN, CRSwNP, COPD, BP (reauth): Pt demonstrates positive clinical response to therapy. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement of 1 of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures). COPD (reauth): Pt cont on triple therapy (ie, an ICS, a LAMA, and a LABA) OR if CI to ICS, a LAMA and a LABA. Chronic Spontaneous Urticaria (CSU) (init): Dx of CSU. Persistent symptoms (itching and hives) with a 2nd generation H1 antihistamine (H1A) (eg, cetirizine, fexofenadine), unless C/I to H1A. Used concurrently with an H1A unless C/I to H1A. CSU (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction from baseline in itching severity or number of hives. Allergic Fungal Rhinosinusitis (AFRS) (init): Dx of AFRS. Pt has history of sino-nasal surgery.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EBGLYSS (S)

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMGALITY (S)

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (120 mg/mL strength only) (initial): Diagnosis of EM. Chronic Migraines (CM) (120 mg strength/mL only) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Episodic Cluster Headache (ECH) (100 mg/mL strength only) (initial): Diagnosis of episodic cluster headache. Medication will not be used in combination with another injectable CGRP inhibitor. EM, CM (120 mg/mL strength only) (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM, ECH (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. ECH (initial): 3 months. EM, CM, ECH (reauth): 12 months.
Other Criteria	EM, CM (120 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (120 mg/mL strength only) (reauth): Patient continues to be monitored for medication overuse headache. ECH (100 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy. Medication will not be used in combination with another injectable CGRP inhibitor.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMPAVELI (S)

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH. Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN) (initial): Diagnosis of C3G or primary IC-MPGN. Used to reduce proteinuria.
Age Restrictions	C3G, Primary IC-MPGN (initial): Patient is 12 years of age or older.
Prescriber Restrictions	PNH (initial): Prescribed by or in consultation with a hematologist or oncologist. C3G, Primary IC-MPGN (initial): Prescribed by or in consultation with a nephrologist.
Coverage Duration	PNH, C3G, Primary IC-MPGN (initial, reauth): 12 months.
Other Criteria	PNH (reauth): Patient demonstrates positive clinical response to therapy. C3G, Primary IC-MPGN (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with a maximally tolerated dose of one of the following: 1) Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril), 2) Angiotensin receptor blockers (e.g., losartan, valsartan), or 3) Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENBREL (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months

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

ENDARI (S)

Products Affected

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Sickle cell disease (initial, reauth): 12 months
Other Criteria	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENSACOVE (S)

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) Locally advanced or b) Metastatic. Disease is anaplastic lymphoma kinase (ALK) rearrangement-positive as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has not previously received an ALK-inhibitor [e.g., Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), Xalkori (crizotinib), Zykadia (ceritinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENTYVIO SC (S)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD. One of the following: 1) Both of the following: a) Patient will receive Entyvio IV induction doses prior to SC maintenance therapy, and b) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: one formulary adalimumab product, Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), or one formulary ustekinumab product, OR 2) Entyvio IV induction therapy has been completed or is currently ongoing. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. One of the following: 1) Both of the following: a) Patient will receive Entyvio IV induction doses prior to SC maintenance therapy, and b) TF/C/I to two of the following: one formulary adalimumab product, Skyrizi, Tremfya, one formulary ustekinumab product, Rinvoq, or tofacitinib, OR 2) Entyvio IV induction therapy has been completed or is currently ongoing
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 14 weeks. CD, UC (reauth): 12 months.
Other Criteria	CD, UC (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPCLUSA PREFERRED (S)

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist. Prescriber requirement does not apply for patient who is Hepatitis C treatment naive without decompensation.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPIDIOLEX (S)

Products Affected

- Epidiolex

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

EPOETIN ALFA (S)

Products Affected

- Procrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of anemia due to CKD. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Dx of anemia due to chemotherapy. Other causes of anemia have been ruled out. Cancer is a non-myeloid malignancy. Patient is receiving chemo. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Not used in patient who is willing to donate autologous blood pre-operatively. Anemia with HIV (Initial): Dx of anemia in patient with HIV infection. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of anemia due to MDS. Dx of lower-risk MDS (e.g., low or intermediate-1 risk [IPSS] or very low / low / intermediate risk [IPSS-R]). Serum erythropoietin level is 500 mU/mL or less.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD, HIV: (init) 6mo, (reauth) 12mo. Chemo (all): 3mo. MDS: (init) 3mo, (reauth) 12mo. Preop: 1mo.

Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of anemia due to CKD. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. MDS (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. All uses except Preop (Reauth): Provider confirms hemoglobin and hematocrit values are appropriate for continuation of therapy or that therapy has been adjusted based on lab values. Other off-label uses: Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERIVEDGE (S)

Products Affected

- Erivedge

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

ERLEADA (S)

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ESBRIET (S)

Products Affected

- Pirfenidone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF.
Age Restrictions	N/A
Prescriber Restrictions	IPF (initial): Prescribed by or in consultation with a pulmonologist
Coverage Duration	initial, reauth: 12 months
Other Criteria	IPF (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EUCRISA (S)

Products Affected

- Eucrisa

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

EVRYSDI (S)

Products Affected

- Evrysdi SOLR

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

FASENRA (S)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype. Symptoms are inadequately controlled with inhaled corticosteroids (e.g., fluticasone propionate, Wixela Inhub [fluticasone propionate/salmeterol], etc).
Age Restrictions	N/A
Prescriber Restrictions	Asthma (Initial): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. EGPA (initial): Prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist. HES (initial): Prescribed by or in consulation with an allergist/immunologist or hematologist.
Coverage Duration	Asthma (init): 6 months. Asthma (reauth): 12 months. EGPA, HES (init/reauth): 12 months.

Other Criteria	Eosinophilic granulomatosis with polyangiitis (EGPA) (Initial): Diagnosis of EGPA. Patient is currently receiving corticosteroid therapy (eg, prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. Asthma (Reauth): Patient demonstrates positive clinical response to therapy. EGPA (reauth): Patient demonstrates positive clinical response to therapy. Hypereosinophilic Syndrome (HES) (init): Diagnosis (dx) of HES. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is FIP1L1-PDGFRA-negative. Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication (CI), or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). HES (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FILSPARI

Products Affected

- Filspari

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

FINTEPLA (S)

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dravet Syndrome: Diagnosis of seizures associated with Dravet syndrome. Lennox-Gastaut Syndrome: Diagnosis of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	All Indications: Patient is 2 years of age or older.
Prescriber Restrictions	All Indications: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FIRAZYR (S)

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. Diagnosis has been confirmed by one of the following: 1) Both of the following: a) C4 level and b) One of the following: i) C1-INH antigenic level or ii) C1-INH functional level, 2) Genetic testing, or 3) Family history. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 18 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FIRMAGON (S)

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FOTIVDA (S)

Products Affected

- Fotivda

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

FRUZAQLA (S)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI), and B) Anti-VEGF biological therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-afibercept]). One of the following: A) Presence of RAS mutation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), OR B) Both of the following: a) Patient has RAS wild-type tumors, AND b) Patient has been previously treated with both of the following: 1) An anti-EGFR biological therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), and 2) One of the following: i) Lonsurf [trifluridine/tipiracil] or ii) Stivarga [regorafenib].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GAVRETO (S)

Products Affected

- Gavreto

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

GILENYA (S)

Products Affected

- Fingolimod Hydrochloride

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

GILOTRIF (S)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): A) Diagnosis of metastatic NSCLC AND B) One of the following: 1) Both of the following: a) Disease is confirmed by non-resistant epidermal growth factor (EGFR) mutations as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy (e.g., cisplatin, carboplatin) and b) squamous NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GLATIRAMER ACETATE (S)

Products Affected

- Glatiramer Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLEEVEC (S)

Products Affected

- Imatinib Mesylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+)/BCR ABL-positive chronic myelogenous leukemia (CML) OR B) Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease OR G) Aggressive systemic mastocytosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLYCOPYRROLATE TABLET (S)

Products Affected

- Glycopyrrolate TABS 1MG, 2MG

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

GOMEKLI (S)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of neurofibromatosis type 1. Patient has plexiform neurofibromas that are both of the following: inoperable and symptomatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GROWTH HORMONE, PREFERRED (S)

Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial): Diagnosis of PGHD. PWS(reauth): evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial): Diagnosis of growth failure in pediatric patient born small for gestational age who has failed to demonstrate catch-up growth. TS,NS(initial): Diagnosis of pediatric growth failure associated with Turner syndrome or Noonan syndrome. SHOX(initial): ped grwth failure dx w/SHOX gene deficiency. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial): ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth): expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months

Other Criteria	AGHD(initial): dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage). AGHD,IGHDA(reauth): monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. IGHDA(initial): Diagnosis of isolated growth hormone deficiency in an adult patient.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HERNEXEOS (S)

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-squamous non-small cell lung cancer (NSCLC). Disease is one of the following: a) unresectable, b) metastatic. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYDROXYZINE ORAL (S)

Products Affected

- Hydroxyzine Hcl TABS 50MG
- Hydroxyzine Hydrochloride SYRP 10MG/5ML
- Hydroxyzine Hydrochloride TABS 10MG, 25MG
- Hydroxyzine Pamoate CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Requested drug is FDA-approved for the condition being treated, or 2) If requested for an off-label indication, the off-label guideline approval criteria have been met. Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	Patient is 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYRNUO (S)

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-squamous non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IBRANCE (S)

Products Affected

- Ibrance CAPS 125MG
- Ibrance TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBTROZI (S)

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: 1) Locally advanced or 2) Metastatic. Presence of ROS1 rearrangement-positive tumor as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ICLUSIG (S)

Products Affected

- Iclusig

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

IDHIFA (S)

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Patient has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH2 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMBRUVICA (S)

Products Affected

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

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

IMKELDI (S)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) CML. Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Ph+/BCR ABL+ ALL. Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD): Diagnosis of MDS/MPD. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: a) HES or b) CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST. All indications: Patient is unable to swallow generic imatinib tablet due to one of the following: a) Age, b) Physical impairment (e.g., difficulties with motor or oral coordination), c) Dysphagia, or d) Patient is using a feeding tube or nasal gastric tube.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INBRIJA (S)

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing intermittent OFF episodes. Patient is currently being treated with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B inhibitor (e.g., rasagiline, selegiline), dopamine agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (initial, reauth): 12 months
Other Criteria	PD (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Used in combination with carbidopa/levodopa.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INCRELEX (S)

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	(Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INGREZZA (S)

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia (initial): Diagnosis of tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease (initial): Diagnosis of chorea in patients with Huntington's disease.
Age Restrictions	N/A
Prescriber Restrictions	Tardive Dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	All Uses (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLURIYO (S)

Products Affected

- Inluriyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor-1 (ESR1) mutation(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLYTA (S)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: (1) used as first-line treatment in combination with avelumab or pembrolizumab or (2) used after failure of one prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INQOVI (S)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic syndrome (MDS): Diagnosis of myelodysplastic syndrome. Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS). Acute Myeloid Leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML). Used in combination with venetoclax. One of the following: a) Patient is 75 years of age or older or b) Patient has comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Both indications: 12 months
Other Criteria	Both indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INREBIC (S)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IRESSA (S)

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Disease is confirmed by known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISTURISA (S)

Products Affected

- Isturisa TABS 1MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's Syndrome (initial): Diagnosis of Cushing's syndrome. Used for treatment of endogenous hypercortisolemia. One of the following: a) Patient is not a candidate for surgery (e.g., adrenalectomy, transsphenoidal surgery), OR b) Surgery has not been curative for the patient.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's Syndrome (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's Syndrome (initial, reauth): 12 months
Other Criteria	Cushing's Syndrome (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ITOVEBI (S)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: a) Locally advanced, or b) Metastatic. Disease is all of the following (as detected by a U.S. Food and Drug Administration [FDA]-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments [CLIA]): a) PIK3CA-mutated, b) Hormone receptor (HR)-positive, c) Human epidermal growth-factor receptor 2 (HER2)-negative. Used following recurrence on or after completing adjuvant endocrine therapy (e.g. Zoladex [goserelin], Arimidex [anastrozole], Nolvadex [tamoxifen]). Used in combination with both of the following: a) Ibrance (Palbociclib), and b) Fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITRACONAZOLE CAPSULE (S)

Products Affected

- Itraconazole CAPS

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

IVERMECTIN (S)

Products Affected

- Ivermectin TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IVIG (S)

Products Affected

- Bivigam INJ 5GM/50ML
- Privigen INJ 20GM/200ML

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

IWILFIN (S)

Products Affected

- Iwilfin

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

JAKAFI (S)

Products Affected

- Jakafi
- Jakafi Xr

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

JAYPIRCA (S)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior therapies for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Disease is one of the following: a) Relapsed, or b) Refractory. Patient has previously been treated with a covalent BTK inhibitor [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JIDEYTRO (S)

Products Affected

- Jideytro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer: Diagnosis of non-small cell lung cancer. Disease is i) locally advanced or ii) metastatic. Presence of ROS1 rearrangement positive tumor(s) as detected by a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior treatment with a ROS1 kinase inhibitor (e.g., Augtyro, Xalkori, Rozlytrek).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JYLAMVO (S)

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neoplastic diseases: Diagnosis of one of the following: A) acute lymphoblastic leukemia (ALL), B) mycosis fungoides (cutaneous T-cell lymphoma), or C) relapsed or refractory non-hodgkin lymphomas. Rheumatoid arthritis (RA): Diagnosis of RA. Psoriasis: Diagnosis of severe psoriasis. Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist. Psoriasis: Prescribed by or in consultation with a dermatologist. pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Neoplastic diseases, RA, Psoriasis, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JYNARQUE (S)

Products Affected

- Tolvaptan TABS

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

Other Criteria	ADPKD (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. One of the following: 1) Patient does not have signs or symptoms consistent with hepatic injury or 2) Patient has uncomplicated polycystic liver disease. One of the following: 1) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KALYDECO (S)

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of cystic fibrosis. Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (initial): Patient is 1 month of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KERENDIA (S)

Products Affected

- Kerendia

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

KESIMPTA (S)

Products Affected

- Kesimpta

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

KINERET (S)

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), tofacitinib, or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID. Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	RA, NOMID (initial): 6 months, (reauth): 12 months. DIRA: 12 months.
Other Criteria	RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KISQALI (S)

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOMZIFTI (S)

Products Affected

- Komzifti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible nucleophosmin 1 (NPM1) mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORLYM (S)

Products Affected

- Mifepristone TABS 300MG

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

KOSELUGO (S)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KRAZATI (S)

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: locally advanced or metastatic. Disease is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Colorectal Cancer (CRC): Diagnosis of CRC. Disease is one of the following: locally advanced or metastatic. Tumor is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA) -approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Erbitux (cetuximab). Patient has received prior treatment with ALL of the following: a) fluoropyrimidine-based chemotherapy, b) oxaliplatin-based chemotherapy, and c) irinotecan-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KUVAN (S)

Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KYGEVVI (S)

Products Affected

- Kygevvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes) confirming all of the following: a) Diagnosis of thymidine kinase 2 deficiency (TK2d), b) Presence of a mutation in the TK2 gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), c) Patient experienced symptom onset on or before 12 years of age.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a clinical specialist knowledgeable in the treatment of TK2d (e.g., geneticist, neurologist).
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Provider attests the patient would benefit from continued therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LAZCLUZE (S)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Used as first line treatment of NSCLC. Used in combination with Rybrevant (amivantamab). Presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LENVIMA (S)

Products Affected

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

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

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LEQEMBI IQLIK

Products Affected

- Leqembi Iqlik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Alzheimer's disease. Disease is confirmed by the presence of beta amyloid pathology (e.g., PET scan, cerebrospinal fluid (CSF) biomarker [e.g., Abeta42 level, Abeta42:Abeta40 ratio, Tau, p-Tau]). Provider attests that monitoring for amyloid related imaging abnormalities (ARIA) will be performed. For Leqembi IQLIK 360mg/1.8mL subcutaneous solution: Will be used as a maintenance dose following completion of 18 months with either Leqembi intravenous or Leqembi IQLIK 500mg. Initial, Reauth: Not used in combination with other Abeta monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by a neurologist, geriatrician, or geriatric psychiatrist.
Coverage Duration	Initial, Reauth: 6 months.
Other Criteria	Reauth: Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LETAIRIS (S)

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bone marrow/stem cell transplant (BMSCT): Patient is undergoing bone marrow or stem cell transplantation, stem cell mobilization or post-transplant support. Acute myeloid leukemia (AML): Diagnosis of AML. Febrile Neutropenia (FN) Prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving dose dense chemotherapy, 2) patient is receiving chemotherapy regimen(s) associated with FN, OR 3)Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of High-Risk FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. HIV-related neutropenia (HIVN): Patient is infected with HIV.
Age Restrictions	BMSCT: Patient is 2 years of age or older.
Prescriber Restrictions	HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist. All other uses:Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	BMSCT, AML, FN (prophylaxis, treatment):3mo or duration of tx. HIVN:6mo. ARS:1 mo.
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIDOCAINE TOPICAL (S)

Products Affected

- Lidocaine OINT 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication or compendia supported use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDOCAINE/PRILOCAINE (S)

Products Affected

- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication or compendia supported use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDODERM (S)

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIFYORLI (S)

Products Affected

- Lifyorli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Disease is platinum resistant. Used in combination with nab-paclitaxel. Patient has received one prior bevacizumab-containing systemic treatment regimen. Patient has not received more than three prior systemic treatment regimens (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LONSURF (S)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. One of the following: A) Used as a single agent or B) Used in combination with bevacizumab. Patient has been previously treated with both of the following: A) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND B) anti-VEGF therapy (e.g., Avastin [bevacizumab]). One of the following: A) Presence of RAS wild-type tumors AND patient has been previously treated with one anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]) OR B) Presence of RAS mutation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Metastatic Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or metastatic gastroesophageal junction adenocarcinoma. Patient has been previously treated with two of the following: A) fluropyrimidine-based chemotherapy (e.g. fluorouracil), B) Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), C) Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, or D) HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LORBRENA (S)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LOTRONEX (S)

Products Affected

- Alosetron Hydrochloride

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

LUMAKRAS (S)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced or b) metastatic. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior therapy with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy. Used in combination with Vectibix (panitumumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUPRON (S)

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPRON DEPOT (S)

Products Affected

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

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

LYNPARZA TABLET (S)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Prostate cancer: Diagnosis of castration-resistant prostate cancer. All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYTGOBI (S)

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of intrahepatic cholangiocarcinoma. Disease is one of the following: a) unresectable, b) locally advanced, or c) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. Patient has been previously treated (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MARINOL (S)

Products Affected

- Dronabinol CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 12 months.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAVYRET (S)

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: 1) One of the following: a) Diagnosis of hepatitis C, or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of hepatitis C, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	One of the following: 1) Non-transplant patient who is treatment-naïve without decompensation, or 2) Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	8 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MAYZENT (S)

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKINIST (S)

Products Affected

- Mekinist

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

Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafinlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafinlar (dabrafenib).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEKTOVI (S)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Presence of BRAF V600E or V600K mutant type (MT) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Presence of BRAF V600E mutant type (MT) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MIGRANAL (S)

Products Affected

- Dihydroergotamine Mesylate SOLN

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

MODEYSO (S)

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of diffuse midline glioma. Disease is confirmed by the presence of H3 K27M mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MOUNJARO (S)

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MS INTERFERONS (PREFERRED) - AVONEX (S)

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MS INTERFERONS (PREFERRED) - BETASERON (S)

Products Affected

- Betaseron

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NERLYNX (S)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Early Stage Breast cancer: Diagnosis (dx) of early stage breast cancer. Advanced or Metastatic Breast Cancer: Dx of advanced or metastatic breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEULASTA (S)

Products Affected

- Neulasta INJ 6MG/0.6ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving dose dense chemotherapy, 2) patient is receiving chemotherapy regimen(s) associated with FN, OR 3) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEXAVAR (S)

Products Affected

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC. One of the following: locally recurrent disease, or metastatic disease. Patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXLETOL (S)

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous familial hypercholesterolemia (HeFH), Primary Hyperlipidemia/Hypercholesterolemia, or Prevention of Cardiovascular (CV) Events in patients at increased risk for major adverse cardiovascular events (Initial): One of the following diagnoses: A) HeFH, B) Primary Hyperlipidemia/Hypercholesterolemia, C) At increased risk for a major adverse CV event (e.g., cardiovascular death, myocardial infarction, stroke, or coronary revascularization). One of the following: 1) Used as adjunct to statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., reduction in LDL-C levels). Patient continues to receive other lipid-lowering tx (e.g., statins, ezetimibe) or patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEXLIZET (S)

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous familial hypercholesterolemia (HeFH), Primary Hyperlipidemia/Hypercholesterolemia, or Prevention of Cardiovascular (CV) Events in patients at increased risk for major adverse cardiovascular events (Initial): One of the following diagnoses: A) HeFH, B) Primary Hyperlipidemia/Hypercholesterolemia, C) At increased risk for a major adverse CV event (e.g., cardiovascular death, myocardial infarction, stroke, or coronary revascularization). One of the following: 1) Used as adjunct to statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., reduction in LDL-C levels). Patient continues to receive other lipid-lowering tx (e.g., statins, ezetimibe) or patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NINLARO (S)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NORTHERA (S)

Products Affected

- Droxidopa

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

NOXAFIL SUSPENSION (S)

Products Affected

- Posaconazole SUSP

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

NUBEQA (S)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic Castration-sensitive prostate cancer (mCSPC): Diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) [also known as metastatic hormone-sensitive prostate cancer (mHSPC)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, mCSPC: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NUCALA (S)

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype. Symptoms are inadequately controlled with inhaled corticosteroids (e.g., fluticasone propionate, Wixela Inhub [fluticasone propionate/salmeterol], etc).
Age Restrictions	N/A
Prescriber Restrictions	Asthma (init): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist.
Coverage Duration	Asthma, COPD (init): 6 mo, (reauth): 12 months. CRSwNP, EGPA, HES (init, reauth): 12 months

Other Criteria	Hypereosinophilic Syndrome (HES) (init): Diagnosis (dx) of HES. Patient (Pt) has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Pt is FIP1L1-PDGFRA-negative. Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication (CI), or intolerance to corticosteroid (CS) therapy (tx) (e.g., prednisone) or cytotoxic/immunosuppressive tx (e.g., hydroxyurea, cyclosporine, imatinib). Asthma (reauth): Pt demonstrates positive clinical response to tx. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Dx of CRSwNP. Unless CI, the pt has had an inadequate response to 2 months of treatment with an intranasal CS (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Dx of EGPA. Pt's disease has relapsed or is refractory to standard of care tx (i.e., CS treatment with or without immunosuppressive tx). Pt is currently receiving CS tx (e.g., prednisolone, prednisone) unless there is a CI or intolerance to CS tx. CRSwNP (reauth): Pt demonstrates positive clinical response to tx. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Pt demonstrates positive clinical response to tx. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells/microliter in the last 12 months. Pt is receiving 1 of the following: a) Triple tx (i.e., ICS, LAMA, and a LABA), or b) If CI to ICS, a LAMA and a LABA. Pt has had 1 of the following within the past 12 months: a) At least 2 exacerbations where systemic CS [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once, or b) COPD-related hospitalization. COPD (reauth): Pt demonstrates clinical benefit from tx, as evidenced by improvement, stabilization, or slowing of disease progression. Pt continues to receive 1 of the following tx: a) Triple tx (i.e., ICS, LAMA, and LABA, or b) If CI to ICS, a LAMA and a LABA.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUEDEXTA (S)

Products Affected

- Dextromethorphan Hydrobromide/quinidine Sulfate

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

NUPLAZID (S)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NURTEC (S)

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Treatment of Migraine (initial): Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	All Indications (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Acute Treatment (init): 12mo. Preventive Treatment (init): 6mo. All Indications (reauth): 12mo.
Other Criteria	Preventive Treatment of Episodic Migraine (EM) (initial): Diagnosis of EM. Acute Treatment of Migraine (reauth): Patient has experienced a positive response to therapy. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines. Preventive Treatment of EM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUVIGIL (S)

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA. Shift-work disorder (SWD) (Initial): Dx of SWD. Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: 12 mo
Other Criteria	OSA, Narcolepsy, SWD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ODOMZO (S)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of basal cell carcinoma. Disease is locally advanced. One of the following: 1) Disease has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OFEV BRAND

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype, Progressive Pulmonary Fibrosis (PPF) (initial): Diagnosis of chronic fibrosing interstitial lung disease or progressive pulmonary fibrosis (PPF). All indications (initial): Trial or intolerance to generic nintedanib.
Age Restrictions	N/A
Prescriber Restrictions	All Indications (initial): Prescribed by or in consultation with a pulmonologist or a rheumatologist.
Coverage Duration	All Indications (initial, reauth): 12 months.
Other Criteria	All Indications (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OFEV GENERIC

Products Affected

- Nintedanib Esylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype, Progressive Pulmonary Fibrosis (PPF) (initial): Diagnosis of chronic fibrosing interstitial lung disease or progressive pulmonary fibrosis (PPF).
Age Restrictions	N/A
Prescriber Restrictions	All Indications (initial): Prescribed by or in consultation with a pulmonologist or a rheumatologist.
Coverage Duration	All Indications (initial, reauth): 12 months.
Other Criteria	All Indications (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OGSIVEO (S)

Products Affected

- Ogsiveo TABS 100MG, 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA (S)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Presence of a BRAF fusion or rearrangement, or BRAF V600 mutation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJJAARA (S)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Patient has anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONUREG (S)

Products Affected

- Onureg

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

OPIPZA (S)

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of Schizophrenia. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: a) aripiprazole (failure or contraindication are not required), b) olanzapine, c) quetiapine IR/ER, d) risperidone, e) clozapine, f) ziprasidone, g) paliperidone, or h) asenapine. Major Depressive Disorder (MDD): Diagnosis of MDD. Used as adjunctive therapy with an antidepressant. Both of the following: a) TF/C/I to quetiapine IR/ER and b) Trial of or intolerance to aripiprazole. Autism: Diagnosis of irritability associated with autistic disorder. Both of the following: a) Trial and failure, contraindication (e.g., age), or intolerance to risperidone and b) Trial of or intolerance to aripiprazole. Tourette's Syndrome: Diagnosis of Tourette's Syndrome. Trial of or intolerance to aripiprazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPSUMIT (S)

Products Affected

- Macitentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENCIA SC (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), tofacitinib, or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel, one formulary adalimumab product, Rinvoq/LQ, or tofacitinib, OR b) for continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: a) Either a TF/C/I to two of the following: Cosentyx SC (secukinumab), Enbrel, one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq/LQ, or tofacitinib, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months

Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENITRAM (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORGOVYX (S)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORKAMBI (S)

Products Affected

- Orkambi TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (Initial): Patient is 6 years of age or older
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORSERDU (S)

Products Affected

- Orserdu

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

OSENVELT (S)

Products Affected

- Osenvelt

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

OSPHENA (S)

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OTEZLA (S)

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OTEZLA XR (S)

Products Affected

- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OZEMPIC (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: 1) Both of the following: A) Fibrosis 4 index (FIB-4) score greater than or equal to 1.3 AND B) One of the following: a) Enhanced liver fibrosis (ELF) test or b) Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan), or 2) One of the following: A) FibroScan aspartate aminotransferase (FAST), B) MRI-aspartate aminotransferase (MAST), C) Magnetic Resonance Elastography combined with fibrosis-4-index (MEFIB), or D) liver biopsy. Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Trulicity, Mounjaro, Ozempic, Rybelsus).
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	12 months
Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Patient has not progressed to cirrhosis. Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Trulicity, Mounjaro, Ozempic, Rybelsus).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OZEMPIC TABLET (S)

Products Affected

- Ozempic TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PEGASYS (S)

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection. Chronic Hepatitis C: Diagnosis of chronic hepatitis C infection. Patient has compensated liver disease. One of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin).
Age Restrictions	N/A
Prescriber Restrictions	Chronic Hepatitis C: Prescribed by or in consultation with one of the following: hepatologist, gastroenterologist, infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	HepB, HepC: 48 wks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PEMAZYRE (S)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced or metastatic. Disease is confirmed by the presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior line of therapy (e.g., chemotherapy). Myeloid/lymphoid neoplasms: Diagnosis of myeloid/lymphoid neoplasms (MLNs). Disease is relapsed or refractory. Disease is confirmed by the presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PENNSAID (S)

Products Affected

- Diclofenac Sodium TOPICAL SOLN 1.5%

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

PIQRAY (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic breast cancer. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Disease is confirmed by the presence of PIK3CA-mutated as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POMALYST BRAND

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM): Diagnosis of MM. Kaposi sarcoma (KS): One of the following: 1) Diagnosis of AIDS-related KS, OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative. Trial or intolerance to pomalidomide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POMALYST GENERIC

Products Affected

- Pomalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM): Diagnosis of MM. Kaposi sarcoma (KS): One of the following: 1) Diagnosis of AIDS-related KS, OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POSACONAZOLE TABLET (S)

Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment (Tx) of SFI: Used as treatment of systemic fungal infections caused by Aspergillus. All indications: Patient weighs greater than 40 kg.
Age Restrictions	All indications: Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All indications: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PRALUENT (S)

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event (init): One of the following diagnoses: A) HeFH, B) ASCVD [e.g., history of acute coronary syndromes (ACS), myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD)], OR C) Primary hyperlipidemia (HLD) or hypercholesterolemia, OR D) At increased risk for a major adverse CV event. One of the following: 1) Patient has been receiving highest tolerable dose of statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (eg, creatine kinase), OR 3) Patient has an FDA labeled contraindication to all statins. HoFH (init): Diagnosis of HoFH. One of the following: 1) Patient is receiving other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe).
Age Restrictions	HeFH (Initial): Patient is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months

Other Criteria	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event (reauth): Patient continues to receive other lipid-lowering therapy (eg, statins, ezetimibe) at max tolerated dose (unless patient has documented inability to take these medications). HoFH (reauth): One of the following: 1) Patient continues to receive other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe). HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROMACTA (S)

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune Thrombocytopenia (ITP) (initial): Diagnosis (dx) of chronic ITP, relapsed/refractory ITP, or persistent ITP. One of the following: i) Patient has had a prior splenectomy, or ii) Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., prednisone, methylprednisolone) or immunoglobulins [e.g., Gammagard, immune globulin (human)]. Chronic Hepatitis C (Hep C)-associated Thrombocytopenia (initial): Dx of chronic Hep C-associated thrombocytopenia. One of the following: i) Planning to initiate and maintain interferon-based treatment, or ii) currently receiving interferon-based treatment. First (1st)-line for Severe Aplastic Anemia (SAA): Dx of SAA. Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy). Used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine). Refractory SAA (initial): Dx of refractory SAA. Insufficient response to immunosuppressive therapy. 1st-line and Refractory SAA (initial): Patient has two of the following: i) neutrophils less than 0.5 x 10^9/L, ii) platelets less than 20 x 10^9/L, or iii) reticulocytes less than 60 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	ITP (init), 1st-line SAA, Refractory SAA (init): Prescribed by or in consultation with a hematologist/oncologist. Hep C (init): Prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	ITP(init,reauth):12mo.HepC init,reauth:12 mo.1stline SAA:6mo.RefractSAA:16wk-init,12mo-reauth.

Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hep C (reauth): Patient demonstrates positive clinical response to therapy. Patient currently on antiviral interferon therapy for treatment of chronic Hep C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROMETHAZINE (S)

Products Affected

- Promethazine Hcl SUPP 12.5MG
- Promethazine Hydrochloride SOLN 6.25MG/5ML
- Promethazine Hydrochloride SUPP 25MG
- Promethazine Hydrochloride TABS
- Promethegan SUPP 25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Requested drug is FDA-approved for the condition being treated, or 2) If requested for an off-label indication, the off-label guideline approval criteria have been met. Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	Patient is 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PROVIGIL (S)

Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA. Shift-work disorder (SWD) (Initial): Dx of SWD. Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy. MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy. Idiopathic Hypersomnia (Initial): Diagnosis of idiopathic hypersomnia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy, MS Fatigue: Init, Reauth: 12 mo. All other indications: Init, Reauth: 6 mo.
Other Criteria	OSA, SWD, MS Fatigue, Narcolepsy, Idiopathic Hypersomnia (Reauth): Patient demonstrates positive clinical response to therapy. Depression (reauth): Patient demonstrates positive clinical response to modafinil therapy. Used as adjunctive therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PULMOZYME (S)

Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PYRUKYND (S)

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

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

QINLOCK (S)

Products Affected

- Qinlock

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

QUALAQUIN (S)

Products Affected

- Quinine Sulfate CAPS 324MG

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

RELGAABI (S)

Products Affected

- Gabapentin CAPS 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of postherpetic neuralgia or partial onset seizures. Trial or intolerance to generic gabapentin (generic Neurontin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REPATHA (S)

Products Affected

- Repatha
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event (init): One of the following diagnoses: A) HeFH, B) ASCVD [e.g., history of acute coronary syndromes (ACS), myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD)], C) Primary hyperlipidemia (HLD) or hypercholesterolemia, OR D) At increased risk for a major adverse CV event. One of the following: a) Patient has been receiving the highest tolerable dose of statin therapy, OR b) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (eg, creatine kinase), OR c) Patient has an FDA labeled contraindication to all statins. HoFH (init): Diagnosis of HoFH. One of the following: 1) Patient is receiving other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe).
Age Restrictions	(Initial) HeFH/HoFH: 10 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months

Other Criteria	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event (reauth): Patient continues to receive other lipid-lowering therapy (eg, statins, ezetimibe) at max tolerated dose (unless patient has documented inability to take these medications). HoFH (reauth): One of the following: 1) Patient continues to receive other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe). HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RETACRIT (S)

Products Affected

- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of anemia due to CKD. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Dx of anemia due to chemotherapy. Other causes of anemia have been ruled out. Cancer is a non-myeloid malignancy. Patient is receiving chemo. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Not used in patient who is willing to donate autologous blood pre-operatively. Anemia with HIV (Initial): Dx of anemia in patient with HIV infection. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of anemia due to MDS. Dx of lower-risk MDS (e.g., low or intermediate-1 risk [IPSS] or very low / low / intermediate risk [IPSS-R]). Serum erythropoietin level is 500 mU/mL or less.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD, HIV: (init) 6mo, (reauth) 12mo. Chemo (all): 3mo. MDS: (init) 3mo, (reauth) 12mo. Preop: 1mo.

Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of anemia due to CKD. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. MDS (Reauth): Patient demonstrates positive clinical response to therapy from pre-treatment level. All uses except Preop (Reauth): Provider confirms hemoglobin and hematocrit values are appropriate for continuation of therapy or that therapy has been adjusted based on lab values. Other off-label uses: Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RETEVMO (S)

Products Affected

- Retevmo TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is locally advanced or metastatic. Presence of rearranged during transfection (RET) gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medullary Thyroid Cancer (MTC): Diagnosis of MTC. Disease is advanced or metastatic. Presence of RET gene mutation tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is advanced or metastatic. Presence of RET gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate. Solid Tumors: Diagnosis of solid tumors. Disease is locally advanced or metastatic. Presence of RET gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). ONE of the following: a) Disease has progressed on or following prior systemic treatment (e.g., chemotherapy), OR b) There are no satisfactory alternative treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	NSCLC, MTC, Thyroid Cancer, Solid Tumors: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REVATIO (S)

Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVCOVI (S)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVLIMID (S)

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Myelodysplastic syndromes (MDS): Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q. Mantle cell lymphoma (MCL): Diagnosis of MCL. Follicular Lymphoma (FL): Diagnosis of FL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVUFORJ (S)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute leukemia: Diagnosis of acute leukemia. Disease is relapsed or refractory. Presence of lysine methyltransferase 2A gene (KMT2A) translocation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Acute myeloid leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Presence of a susceptible nucleophosmin 1 (NPM1) mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZDIFFRA (S)

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: 1) Both of the following: A) Fibrosis 4 index (FIB-4) score greater than or equal to 1.3, and B) One of the following: i) Enhanced liver fibrosis (ELF) test or ii) Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan), or 2) One of the following: A) FibroScan aspartate aminotransferase (FAST), B) MRI-aspartate aminotransferase (MAST), C) Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB), or D) Liver biopsy. Medication will not be used in combination with Wegovy (semaglutide) for the treatment of MASH. Trial and failure, intolerance, or contraindication to Wegovy SC.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: gastroenterologist, endocrinologist, or hepatologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Patient has not progressed to cirrhosis. Medication will not be used in combination with Wegovy (semaglutide) for the treatment of MASH.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REZLIDHIA (S)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate, chemotherapy].
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	cGVHD (initial, reauth): 12 months
Other Criteria	cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ (S)

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA)(init): Diagnosis (Dx) of moderately to severely active RA. RA,PJIA(init): Minimum (min) duration of a 3-mo(RA)/6-wk(PJIA) trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, (RA only) sulfasalazine. Psoriatic arthritis (PsA)(init): Dx of active PsA. Ankylosing spondylitis (AS)(init): Dx of active AS. Non-radiographic axial spondyloarthritis(NRAS, init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one TNF inhibitors (TNF-I) (eg, certolizumab pegol). AS, NRAS(init): Min duration of a 1-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PJIA, PsA, AS(init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab, etanercept). RA, PJIA, PsA, AS, NRAS(init, reauth): Not used in combo with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine [AZA], cyclosporine [CYC]). Atopic dermatitis(AD)(init): Dx of moderate to severe AD. One of the following: 1) TF of a min 12-wk supply of one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent), OR 2) Pt has a C/I, or treatment is inadvisable with one systemic treatment. Not used in combo with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC).
Age Restrictions	N/A

Prescriber Restrictions	RA, PJIA, AS, NRAS, GCA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. CD, UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA, PJIA, PsA, AS, NRAS, CD, UC, AD, GCA (init): 6 months, (reauth): 12 months.
Other Criteria	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. Crohn's disease (CD) (init): Dx of moderately to severely active CD. Ulcerative colitis (UC) (init): Dx of moderately to severely active UC. CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab), OR if treatment is inadvisable (ie, CI) with a TNF-I, pt has had a trial of a systemic therapy approved for CD/UC (eg, risankizumab, ustekinumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC). Giant cell arteritis (GCA) (init): Dx of GCA. GCA (reauth): Pt demonstrates positive clinical response to therapy. GCA (init, reauth): Not used in combo with other JAK-I, biologic DMARDs, or potent immunosuppressants (eg, AZA, CYC). RA, PJIA (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (ESR, CRP), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC). CD/UC (Reauth): Pt demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ LQ (S)

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Diagnosis of active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. Psoriatic arthritis (PsA) (init): Diagnosis of active PsA. PJIA, PsA (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). PJIA, PsA (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	PJIA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	PJIA, PsA (init): 6 months, (reauth): 12 months.
Other Criteria	PJIA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RIVFLOZA (S)

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary hyperoxaluria type 1 (PH1). Patient has preserved kidney function (e.g., eGFR greater than or equal to 30mL/min/1.73m^2). Patient is not receiving Rivfloza in combination with Oxlumo (lumasiran).
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Patient is not receiving Rivfloza in combination with Oxlumo (lumasiran).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROMVIMZA (S)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of tenosynovial giant cell tumor (TGCT). Patient is symptomatic. Surgical resection will potentially cause worsening functional limitation or severe morbidity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROZLYTREK (S)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic (NSCLC). Presence of ROS1 rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Solid Tumors: Diagnosis of solid tumors. Presence of neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). No known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: disease has progressed following previous treatment (e.g., surgery, radiation therapy, or systemic therapy) or disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUBRACA (S)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Prostate cancer: Diagnosis of castration-resistant prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYDAPT (S)

Products Affected

- Rydapt

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

SABRIL (S)

Products Affected

- Vigabatrin
- Vigadrone

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

SANDOSTATIN (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy. Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SCEMBLIX (S)

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Presence of a Philadelphia chromosome-positive (Ph+) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease is in chronic phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIGNIFOR (S)

Products Affected

- Signifor

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

SKYCLARYS (S)

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Friedreich's ataxia confirmed via genetic testing demonstrating mutation in the FXN gene.
Age Restrictions	Initial: Patient is 16 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Physiatrist (Physical Medicine and Rehabilitation Specialist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYRIZI (S)

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 55MG/0.37ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months

Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOMAVERT (S)

Products Affected

- Somavert

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

SPEVIGO (S)

Products Affected

- Spevigo INJ 150MG/ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized pustular psoriasis (GPP). Subcutaneous formulation will not be used to treat GPP flare. Patient weighs at least 40kg.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRYCEL (S)

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Philadelphia chromosome positive (Ph+)/BCR ABL chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML. Ph+/BCR ABL acute lymphoblastic leukemia (ALL): Diagnosis of Ph+/BCR ABL ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STARJEMZA (S)

Products Affected

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

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

STEQEYMA (S)

Products Affected

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

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

STIVARGA (S)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Gastrointestinal stromal tumor (GIST): Diagnosis of locally advanced, unresectable or metastatic GIST. Hepatocellular Carcinoma (HCC): Diagnosis of HCC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUCRAID (S)

Products Affected

- Sucraid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Congenital Sucrase-Isomaltase Deficiency (CSID) (initial): Diagnosis of sucrase deficiency (which is part of congenital sucrose-isomaltase deficiency [CSID]).
Age Restrictions	CSID (initial): Patient is 5 months of age or older.
Prescriber Restrictions	CSID (initial): Prescribed by or in consultation with a gastroenterologist or geneticist.
Coverage Duration	CSID (initial, reauth): 12 months.
Other Criteria	CSID (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUTENT (S)

Products Affected

- Sunitinib Malate

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

SYPRINE (S)

Products Affected

- Trientine Hydrochloride

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

TABRECTA (S)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFAMIDIS (S)

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Presence of a transthyretin (TTR) mutation (e.g., V122I) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) Both of the following: i) echocardiogram or cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis, and ii) absence of light-chain amyloidosis. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal).
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): 12 months
Other Criteria	ATTR-CM (reauth): Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFINLAR (S)

Products Affected

- Tafinlar

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

Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Presence of BRAF V600E mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib). Low-grade Glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Presence of BRAF V600E mutation type as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAGRISSO (S)

Products Affected

- Tagrisso

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

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	NSCLC cont: OR D) All of the following: Diagnosis of NSCLC. Disease is Locally advanced, Unresectable (Stage III). Disease is confirmed by the presence of known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy. All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TALZENNA (S)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer (mCRPC). Presence of homologous recombination repair (HRR) gene-mutation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TARCEVA (S)

Products Affected

- Erlotinib Hydrochloride TABS

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

TARGRETIN (S)

Products Affected

- Bexarotene

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

TARPEYO

Products Affected

- Tarpeyo

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

TASIGNA (S)

Products Affected

- Nilotinib Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAVNEOS

Products Affected

- Tavneos

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

TECFIDERA (S)

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEPMETKO (S)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping alterations as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TERIPARATIDE (S)

Products Affected

- Bonsity
- Teriparatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis or men with primary or hypogonadal osteoporosis (initial): Diagnosis of one of the following confirmed by T-score or fracture: a) postmenopausal osteoporosis or b) primary or hypogonadal osteoporosis. One of the following: 1) history of osteoporotic fracture or multiple risk factors for fracture, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]). Glucocorticoid-Induced Osteoporosis: See Other Criteria section.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial): 24 months. All uses (reauth): 12 months.
Other Criteria	Glucocorticoid-Induced Osteoporosis (initial): Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months. Patient is at high risk for fracture. All uses (initial, reauth): One of the following: 1) Treatment duration of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient's lifetime, or 2) Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)].

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TESTOSTERONE (S)

Products Affected

- Testosterone GEL 20.25MG/1.25GM, 25MG/2.5GM, 40.5MG/2.5GM, 50MG/5GM
- Testosterone Cypionate INJ 100MG/ML, 200MG/ML
- Testosterone Pump GEL 12.5MG/ACT, 20.25MG/ACT

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

Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TESTOSTERONE ENANTHATE (S)

Products Affected

- Testosterone Enanthate INJ

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

Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GD: 12 mo. DP: 6 mo.
Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

THALOMID (S)

Products Affected

- Thalomid CAPS 100MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): One of the following: a) Diagnosis of moderate to severe ENL with cutaneous manifestations, or b) Used as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence. Thalomid is not used as monotherapy if moderate to severe neuritis is present.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TIBSOVO (S)

Products Affected

- Tibsovo

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

TOFACITINIB (S)

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tofacitinib tab/Tofacitinib XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Tofacitinib tab and solution/Tofacitinib XR tab: Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. Tofacitinib tab/Tofacitinib XR tab: Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). Tofacitinib tab/Tofacitinib XR tab: Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA/PJIA/PsA/AS (initial): 6 mo, (reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.

Other Criteria	Tofacitinib: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, PJIA (Initial): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. RA, PsA, AS, PJIA (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPICAL RETINOID (S)

Products Affected

- Tretinoin CREA 0.025%, 0.05%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRELSTAR (S)

Products Affected

- Trelstar Mixject INJ 11.25MG, 22.5MG

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

TREMFYA SC (S)

Products Affected

- Tremfya INJ 100MG/ML, 200MG/2ML
- Tremfya Induction Pack For Crohns Disease/ulcerative Colitis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. Crohn's disease (CD) (initial): Diagnosis of moderately to severely active CD. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All Indications (Initial): 6 months, (reauth): 12 months
Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIKAFTA (S)

Products Affected

- Trikafta TBPK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). CFTR mutation is responsive based on clinical and/or in vitro data OR CFTR mutation results in the production of CFTR protein.
Age Restrictions	CF (initial): For granule packets: patient is at least 2 to less than 6 years of age. For tablets: patient is 6 years of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRULICITY (S)

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUQAP (S)

Products Affected

- Truqap TABS 200MG
- Truqap TBPK 160MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Used in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of one or more PIK3CA/AKT1/PTEN-alterations as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Disease progression following at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Disease recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy). Prostate Cancer: Diagnosis of prostate cancer. Disease is metastatic. Used in combination with abiraterone and prednisone. Disease is androgen pathway modulation-naïve or -sensitive (mAPMN/S). Tumor is PTEN deficient as detected by a FDA approved test or a test performed at a facility approved by Clinical Laboratory Amendments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRYNGOLZA (S)

Products Affected

- Tryngolza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia). One of the following: a) Disease is confirmed by the presence of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), or b) A North American FCS (NAFCS) Score of greater than or equal to 45, or c) A Moulin score greater than 10. Requested drug will not be used in combination with Redemplo (plozasiran).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or lipid specialist (lipidologist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Redemplo (plozasiran).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TUKYSA (S)

Products Affected

- Tukysa

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

TURALIO (S)

Products Affected

- Turalio CAPS 125MG

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

TYENNE SC (S)

Products Affected

- Tyenne INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to one of the following: Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), tofacitinib, or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to one of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Rinvoq/LQ, or tofacitinib, OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD.
Age Restrictions	N/A
Prescriber Restrictions	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months

Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYKERB (S)

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer. One of the following: 1) All of the following: a) Disease is one of the following: Advanced OR Metastatic, b) All of the following: i) Patient has received prior therapy with an anthracycline, ii) Patient has received prior therapy with a taxane, AND iii) Patient has experienced disease progression while on trastuzumab therapy, AND c) Used in combination with Xeloda (capecitabine), or 2) Both of the following: a) Disease is BOTH of the following: Metastatic AND Hormone receptor positive (HR+), AND b) Used in combination with Femara (letrozole).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYMLOS (S)

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses confirmed by T-score or fracture: 1) postmenopausal osteoporosis or osteopenia, OR 2) primary or hypogonadal osteoporosis or osteopenia. One of the following: 1) history of osteoporotic fracture or multiple risk factors for fracture, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]). Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (max 24 months of therapy per lifetime)
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UBRELVY (S)

Products Affected

- Ubrelvy

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

UDENYCA (S)

Products Affected

- Udenyca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving dose dense chemotherapy, 2) patient is receiving chemotherapy regimen(s) associated with FN, OR 3) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VALCHLOR (S)

Products Affected

- Valchlor

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

VANFLYTA (S)

Products Affected

- Vanflyta

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

VENCLEXTA (S)

Products Affected

- Venclexta
- Venclexta Starting Pack

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

VEOZAH (S)

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe vasomotor symptoms due to menopause. Prescriber attests that baseline serum alanine aminotransferase (ALT), serum aspartate aminotransferase (AST) and total bilirubin levels are less than 2 times the upper limit of normal (ULN) prior to initiating Veozah.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. One of the following within the past 3 months: a) For patients with total bilirubin levels less than or equal to 2 times the ULN, transaminase elevations do not exceed 5 times the ULN, or b) For patients with total bilirubin levels greater than 2 times the ULN, transaminase elevations do not exceed 3 times the ULN.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VERQUVO (S)

Products Affected

- Verquvo

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

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERZENIO (S)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VIGAFYDE (S)

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial or intolerance to generic vigabatrin.
Age Restrictions	Patient is 1 month to 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VITRAKVI (S)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Presence of solid tumors. Both of the following: i) Disease is confirmed by the presence of neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and ii) Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]. Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VONJO (S)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Pre-treatment platelet count below 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORANIGO (S)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of astrocytoma or oligodendroglioma. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORICONAZOLE INJECTION (S)

Products Affected

- Voriconazole INJ 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOSEVI (S)

Products Affected

- Vosevi

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

VOTRIENT (S)

Products Affected

- Pazopanib Hydrochloride TABS 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOWST (S)

Products Affected

- Vowst

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

VUMERITY (S)

Products Affected

- Vumerity

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

VYVGART (S)

Products Affected

- Vyvgart Hytrulo INJ 1000MG/5ML; 10000UNIT/5ML

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

WEGOVY (S)

Products Affected

- Wegovy INJ

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

WEGOVY TABLETS (S)

Products Affected

- Wegovy TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Initial: Treatment is being requested to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke). Submission of medical records (e.g., chart notes) documenting that patient has established cardiovascular disease as evidenced by one of the following: A) prior myocardial infarction (MI), B) prior stroke, or C) peripheral arterial disease. BMI greater than or equal to 27 kg/m2. Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Trulicity, Mounjaro, Ozempic, Rybelsus).
Age Restrictions	Initial: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Trulicity, Mounjaro, Ozempic, Rybelsus).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WELIREG (S)

Products Affected

- Welireg

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

WINREVAIR (S)

Products Affected

- Winrevair

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

WYOST (S)

Products Affected

- Wyost

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

XALKORI (S)

Products Affected

- Xalkori

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

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XATMEP (S)

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL). Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	ALL, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XCOPRI (S)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XENAZINE (S)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication, OR 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Trial and failure, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	N/A
Prescriber Restrictions	HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XERMELO (S)

Products Affected

- Xermelo

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

XIFAXAN (S)

Products Affected

- Xifaxan

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

XOLAIR (S)

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of moderate to severe persistent allergic asthma. Positive skin test or in vitro reactivity to a perennial aeroallergen. One of the following: A) All of the following: a) Patient is 6 years of age or older but less than 12 years of age, b) Pretreatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100-200 mcg fluticasone propionate equivalent/day), and 2) Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR ii) One medium dosed combination ICS/LABA product (eg, Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]), OR B) All of the following: a) Patient is 12 years of age or older, b) Treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day], and 2) Additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR ii) One maximally-dosed combination ICS/LABA product [eg, Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/ formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	IgE-Mediated Food Allergy (init): Patient is 1 year of age or older.

Prescriber Restrictions	Asthma (init): Prescribed by or in consultation with an allergist/immunologist, or pulmonologist. CSU (init): Prescribed by or in consultation with an allergist/immunologist, or dermatologist. CRSwNP (init/reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. IgE-Mediated Food Allergy (Init/Reauth): Prescribed by or in consultation with an allergist/immunologist.
Coverage Duration	Asthma, CSU, Allergy (init, reauth): 12 months. CRSwNP: 12 months.

Other Criteria	Asthma (reauth): Patient demonstrates positive clinical response to therapy. Chronic Spontaneous Urticaria (CSU) (init): Diagnosis of CSU. Persistent symptoms (itching and hives) with a second generation H1 antihistamine (eg, cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines. Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. CSU (reauth): Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline. Chronic Rhinosinusitis with Nasal polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for chronic rhinosinusitis with nasal polyps. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for chronic rhinosinusitis with nasal polyps. IgE-Mediated Food Allergy (Initial): One of the following: A) Both of the following: 1) Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following: a) Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food, b) Positive food specific IgE (greater than or equal to 6 kUA/L), c) Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein, AND 2) Clinical history of IgE Mediated Food Allergy, OR B) Provider attestation that patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods. Used in conjunction with food allergen avoidance. Baseline (pre-Xolair tx) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL. Dosing is according to serum total IgE levels and body weight. IgE-Mediated Food Allergy (Reauth): Patient demonstrates positive clinical response to therapy. Used in conjunction with food allergen avoidance. Dosing will continue to be based on body weight and pretreatment total IgE serum levels.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLREMDI (S)

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Presence of genotype confirmed variant of CXCR4 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has an absolute neutrophil count (ANC) less than 500 cells/µL.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: immunologist, hematologist, geneticist, dermatologist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XOSPATA (S)

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Patient has a FMS-like tyrosine kinase (FLT3) mutation as determined by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XPOVIO (S)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM), Diffuse large B-cell lymphoma (DLBCL): Diagnosis of one of the following: 1) DLBCL OR 2) Multiple Myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XTANDI (S)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic castration-sensitive prostate cancer. Non-metastatic castrion-sensitive prostate cancer (nm-CSPC): Diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC). Patient has high-risk biochemical recurrence (BCR) defined by a PSA doubling time less than or equal to 9 months and one of the following: A) PSA values greater than or equal to 1 ng/mL if the patient had prior prostatectomy (with or without radiotherapy) OR B) PSA values at least 2 ng/mL above the nadir if the patient had prior radiotherapy only.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XYREM (S)

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND One of the following: a) patient is under 18 years of age or b) trial and failure, contraindication or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
Age Restrictions	All Indications (initial): Patient is 7 years of age or older.
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YESINTEK SC (S)

Products Affected

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

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

YONSA

Products Affected

- Yonsa

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

YULITHIRA (S)

Products Affected

- Yulithira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma. Trial and failure, contraindication, or intolerance to Sutent (sunitinib) or Nexavar (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET. Disease is unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer. Trial and failure, contraindication, or intolerance to Femara (letrozole) or Arimidex (anastrozole). Neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin. Disease is unresectable, locally advanced, or metastatic.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months.
Other Criteria	All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZAVESCA (S)

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease. Niemann-Pick disease type C (NPC) (off-label) (initial): Diagnosis of NPC. Requested drug will be used in combination with Miplyffa (arimoclomol).
Age Restrictions	Gaucher disease: Patient is 18 years of age or older.
Prescriber Restrictions	NPC (initial): Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C.
Coverage Duration	Gaucher disease: 12 months. NPC (initial): 6 months, (reauth): 12 months.
Other Criteria	NPC (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression. Requested drug will be used in combination with Miplyffa (arimoclomol).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEJULA (S)

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	First-Line Maintenance Treatment of Homologous Recombination Deficiency (HRD)-Positive Advanced Ovarian Cancer: Diagnosis of one of the following: a) Advanced epithelial ovarian cancer, b) Advanced fallopian tube cancer, or c) Advanced primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to first-line platinum-based chemotherapy (e.g., cisplatin, carboplatin). Cancer is associated with HRD-positive status defined by one of the following: a) Presence of deleterious or suspected deleterious BRCA mutation or b) Genomic instability. Maintenance Treatment of Recurrent Germline BRCA-Mutated Ovarian Cancer: Diagnosis of one of the following: a) Recurrent epithelial ovarian cancer, b) Recurrent fallopian tube cancer, or c) Recurrent primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin). Presence of deleterious or suspected deleterious germline BRCA-mutations (gBRCAmut) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZELBORAF (S)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All indications: Approve for continuation of therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZENBEXUS (S)

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma. Patient has received at least one prior line of therapy including both of the following: a) One proteasome inhibitor (e.g., bortezomib), and b) One immunomodulatory agent (e.g., pomalidomide, lenalidomide). Used in combination with both of the following: a) Darzalex (daratumumab) or Darzalex Faspro (daratumumab and hyaluronidase-fihj), and b) Dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEPOSIA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Failure after a trial of at least 4 weeks, contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy. Ulcerative Colitis (UC) (init): Diagnosis of moderately to severely active UC. One of the following: a) Trial and failure, contraindication, or intolerance (e.g., an injectable may not be tolerated or advisable) to two of the following: one formulary adalimumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq (upadacitinib), or tofacitinib, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist. UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (initial, reauth): 12 months. UC (init): 6 months, (reauth): 12 months.
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression). UC (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZOKINVY (S)

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with presence of one of the following mutations as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA): i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m^2 and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOLINZA (S)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or following two systemic therapies (e.g., bexarotene, romidepsin, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZTALMY (S)

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Disease is confirmed by the presence of a mutation in the CDKL5 gene as detected by a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZURZUVAE (S)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): Diagnosis of PPD. Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYKADIA (S)

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC) that is metastatic or recurrent. Disease is confirmed by the presence of an anaplastic lymphoma kinase (ALK)-positive tumor as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYMFENTRA

Products Affected

- Zymfentra 2-pen
- Zymfentra 2-syringe

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD. Ulcerative colitis (UC) (initial): Diagnosis of moderately to severely active UC. CD, UC (initial): Patient has achieved a clinical response following three induction doses of a formulary intravenous infliximab product (e.g., Avsola, Inflectra, or Renflexis).
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 6 months. CD, UC (reauth): 12 months.
Other Criteria	CD, UC (reauth): Patient demonstrates clinical benefit from therapy, as evidenced by improvement, stabilization, or slowing of disease progression.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZYTIGA (PREFERRED) (S)

Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-Resistant Prostate Cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Castration-Sensitive Prostate Cancer (CSPC): Diagnosis of castration-sensitive prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, CSPC: 12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PART B VERSUS PART D

Products Affected

- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant
- Azathioprine TABS 50MG
- Budesonide SUSP
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nutrilipid
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prograf PACK
- Rabavert
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tacrolimus Er
- Tobramycin NEBU 300MG/5ML
- Yupelri

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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