Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Adcirca

Products Affected

- ALYQ
- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	Using tadalafil-PAH formulations for the treatment of erectile dysfunction.
Required Medical Information	For initial use, Individual has diagnosis of Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1. Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units. AND Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Pulmonary Arterial Hypertension, individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units. AND Individual has WHO functional class II- IV symptoms. For CTEPH a right-heart catheterization showing a mPAP greater than 25 mm Hg caused by thromboemboli in the pulmonary arterial system (ACCF/AHA 2009).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Initial use, for diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 AND has WHO functional class II-IV symptoms. For diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4 AND has WHO functional class II-IV symptoms AND using for one of the following: Persistent or recurrent pulmonary hypertension after at least 180 days following surgical treatment with pulmonary endarterectomey OR Inoperable (via pulmonary endarterectomey) CTEPH. For continued use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AED Agents

Products Affected

- *brivaracetam oral solution*
- *brivaracetam oral tablet*
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET
- DILANTIN ORAL CAPSULE 30 MG
- EPRONTIA
- LAMICTAL XR ORAL KIT
- *levetiracetam oral tablet disintegrating soluble*
- *perampanel oral suspension*
- *perampanel oral tablet*
- SPRITAM ORAL TABLET
- XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK
- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AFINITOR

Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- YULITHIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Aimovig

Products Affected

- AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Episodic migraine defined as at least 4 and fewer than 15 migraine days per month and fewer than 15 headache days per month on average during the previous 3-month period. Chronic migraine defined as a headache occurring on 15 or more days per month for more than 3 months, which, on at least 8 days per month, has features of a migraine headache (ICHD-3 beta).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Continuation: 1 year

PA Criteria	Criteria Details
Other Criteria	For initial requests: (I) Individual has a diagnosis of one of the following: (a) Episodic migraine OR (b) Chronic migraine AND (II) Individual is using for migraine prophylaxis. And (III) If individual is also currently using botulinum toxin for prophylaxis and is going to be using Aimovig and botulinum toxin together (i.e., not switching from one agent to another), the following will apply: (a) Individual has had a reduction in the overall number of migraine days or reduction in number of severe migraine days per month with the initial agent AND (b) Individual continues to experience a significant number of migraine headache days or severe migraine days per month requiring additional therapy for migraine prevention. For Renewal requests: (I) Individual has a reduction in the overall number of migraine days or reduction of severe migraine days per month AND (II) Individual has obtained clinical benefit deemed significant by individual or prescriber including any of the following (AHS 2019): (a) 50% reduction in frequency of days with headache or migraine OR (b) Significant decrease in attack duration OR (c) Significant decrease in attack severity OR (d) Improved response to acute treatment OR (e) Reduction in migraine-related disability and improvements in functioning in important areas of life OR (f) Improvements in health related quality of life and reduction in psychological stress due to migraine. AND If individual is using concurrently with botulinum toxin for migraine prophylaxis, the following will apply: Individual has had further reduction in the overall number of migraine days or reduction in number of severe migraine days per month compared to monotherapy with the initial agent (either botulinum toxin or CGRP).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Akeega

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mCRPC, BRCA-mutation status. For mCSPC, BRCA2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual meets one of the following: (A) Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog (e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix) OR (B) Has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Alpha1-Proteinase Inhibitor

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Initial use, verified alpha-1 antitrypsin level is less than or equal to 11micro-mol/L (approximately equivalent to 80mg/dL measured by radial immunodiffusion or 57 mg/dL measured by nephelometry) (ATS/ERS 2003, Stoller 2017). Individual has clinically evident emphysema (or chronic obstructive pulmonary disease [COPD]).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Continued use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to decreased frequency of exacerbations, slowed rate of FEV1 decline, preservation of CT scan lung density or improvement in symptom burden).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Alunbrig

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Amphetamine Salts

Products Affected

- *amphetamine-dextroamphet er*
- *amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ampyra

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renewal, individual achieved and sustained improvement in ambulation related functional status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Apokyn

Products Affected

- *apomorphine hcl subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Erectile Dysfunction (ED) use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use in PD, individual is using in conjunction with an antiemetic (excluding 5HT3 antagonist agents) during initiation period. For continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, for DIRA, IL1RN mutation status AND disease is in remission from previous anakinra treatment. For Recurrent Pericarditis (RP), individual is using for treatment of RP or reduction in risk of recurrence AND has a history of at least two pericarditis episodes (i.e. presents with at least the third episode) (Klein 2021).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continued use, individual has been receiving and is maintained on a stable dose of Arcalyst AND mbr has clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by prescriber.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Augtyro

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status. For solid tumor, NTRK gene fusion status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Austedo

Products Affected

- AUSTEDO
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial requests, Individual has a diagnosis of chorea associated with Huntington's disease. Has a diagnosis of Tardive dyskinesia confirmed (written or verbal attestation) by the following DSM-5 AND (a.) At least 30 days of stable (drug, dose) medication exposure (either typical or first generation antipsychotic agents [such as, chlorpromazine, haloperidol, fluphenazine], atypical or second-generation antipsychotic agents [such as, clozapine, risperidone, olanzapine, quetiapine, aripiprazole], or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis [such as, prochlorperazine, promethazine, metoclopramide]) and (b.) Presence of involuntary athetoid or choreiform movements. For continuation requests, Individual has experienced slowing of disease progression or an improvement in symptoms deemed to be clinically significant by the provider based on stabilization or improvement in Abnormal Involuntary Movement Scale (AIMS) score (for TD) or total maximal chorea score (for Huntington's disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Auvelity

Products Affected

- AUVELITY
- AUVELITY TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For MDD or for treatment of agitation associated with dementia due to Alzheimer's disease.
Age Restrictions	For MDD, Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Avmapki Fakzynja

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Ovarian Cancer, KRAS mutation status. Individual has an Eastern Cooperative Group (ECOG) performance status of 0-1.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ayvakit

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Advanced Systemic Mastocytosis (AdvSM) and Indolent Systemic Mastocytosis (ISM), individual has a platelet count of greater than or equal to 50 x 109/L. For GIST, PDGFRA exon 18 mutation status, including PDGFRA D842V mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Balversa

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mUC, written or verbal attestation is provided to confirm FGFR3 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Banzel

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	Individual is 1 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Bempedoic Acid Agents

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual is at high risk for atherosclerotic cardiovascular disease (ASCVD) events as identified by one of the following: (A) Individual has Heterozygous Familial Hypercholesterolemia (HeFH) verified by (Singh 2015, WHO 1999): (1) Presence of a mutation in LDLR, ApoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene OR (2) WHO/Dutch Lipid Clinic Network criteria with score of greater than eight points OR (B) Individual has a history of or is at HIGH risk for clinical ASCVD, including one or more of the following (AHA/ACC 2018): Acute coronary syndrome, Coronary artery disease (CAD), History of MI, Stable or unstable angina, Coronary or other arterial revascularization, Stroke, Transient ischemic attack (TIA), Peripheral arterial disease (PAD), CV death OR (C) has primary hyperlipidemia. For HeFH and Primary Hyperlipidemia individual is using alone when concomitant low-density lipoprotein cholesterol (LDL-C) lowering therapy is not possible or in combination with other LDL-C lowering therapies. Individual has achieved suboptimal lipid lowering response to lipid lowering therapy as defined (AHA/ACC 2018): (A) For individuals where initial LDL-C is known: (1) Less than 50% reduction in LDL-C OR (B) For individuals where initial LDL-C is unknown: (1) ASCVD and LDL-C remains greater than or equal to 55 mg/dL OR (2) No history of ASCVD and LDL-C remains greater than or equal to 70 mg/dL.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 Year.
Other Criteria	For Continuation, individual is achieving a reduction in LDL-C OR individual demonstrates positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial tx (IV or Subcutaneous), individual has a diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND dx was verified by hx of positive ANA titer greater than or equal to 1:80 or anti-dsDNA greater than or equal to 30 IU/mL AND disease is active as shown by a SELENA-SLEDAI score greater than or equal to 6 while on current treatment regimen AND SLE remains active while on corticosteroid, antimalarials, and/or immunosuppressants for at least the last 30 days AND is using in combination with standard therapy (for example, corticosteroids, antimalarials, and/or immunosuppressants [but not other biologics or IV cyclophosphamide]). For Initial tx (IV or Subcutaneous) of active lupus nephritis, individual has Class III, IV, or V lupus nephritis showing active or chronic lesions, and confirmed by renal biopsy AND has a urinary protein to creatinine ratio of greater than or equal to 1 AND did not have disease progression to lupus nephritis while on Benlysta therapy for SLE without LN AND disease remains active while on corticosteroids, antimalarials, or immunosuppressants (alone or as combination therapy) for at least the last 30 days AND is using in combination with standard therapy (for example, corticosteroids, antimalarials, and/or immunosuppressants [but not other biologics or IV cyclophosphamide]). For continuation of therapy (IV or Subcutaneous), verification of previous improvement in disease activity following treatment with belimumab indicating a therapeutic response including lack of disease progression to lupus nephritis while on Benlysta if initially only using for SLE without LN AND there is no evidence of active central nervous system lupus. AND individual is using in combination with standard therapy (for example, corticosteroids, antimalarials, and/or immunosuppressants [but not other biologics or IV cyclophosphamide]).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Beqalzi

Products Affected

- BEQALZI ORAL TABLET 1 MG, 20 MG, 5 MG, 80 MG
- BEQALZI STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Besremi

Products Affected

- BESREMI
- BESREMI PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bimzelx

Products Affected

- BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML, 320 MG/2ML
- BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML, 320 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic moderate to severe (that is, extensive or disabling) plaque psoriasis (Ps) as confirmed by one of the following (AAD 2019): (A) involving greater than or equal to three percent (3%) body surface area (BSA) OR (B) involving less than three percent (3%) BSA involving sensitive areas or areas that significantly impact daily function (such as, palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Initial use: Ps, mbr has an inadequate response to, is intolerant of phototherapy or other systemic therapy (such as acitretin, cyclosporine, or MTX) OR has a CI to phototherapy, acitretin, cyclosporine, or MTX). For AS, mbr has had an inadequate response to or is intolerant of conventional therapy [such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine)] (ACR 2019) OR Has CI to NSAIDs or SZA. For nr-axSpA, mbr has had an inadequate response to or is intolerant of conventional therapy [such as NSAIDs or nonbiologic DMARDs (such as SZA)] (ACR 2019) OR has a CI to NSAIDs or SZA. For HS, mbr has had an inadequate response to or is intolerant of conventional therapy (such as oral antibiotics) OR has a CI to oral antibiotics. Using for PsA. For continuation, mbr has been receiving and is maintained on a stable dose of bimekizumab-bkzx AND has clinically significant improvement or stabilization in clinical signs and symptoms of dz.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Bosulif

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	The individual has one of the following mutations: T315I, V299L, G250E, or F317L.
Required Medical Information	For CML/ALL, Philadelphia Chromosome status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Braftovi

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For melanoma, NSCLC, colon/rectal BRAF V600 status. For colon/rectal dMMR/MSI-H or POLE/POLD1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Brukinsa

Products Affected

- BRUKINSA ORAL CAPSULE
- BRUKINSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has no prior BTK inhibitor usage.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Buphenyl

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Using as adjunctive therapy for chronic management of hyperammonemia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation, there is clinically significant improvement or stabilization in plasma ammonia level.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Bysanti

Products Affected

- BYSANTI
- BYSANTI TITRATION PACK A
- BYSANTI TITRATION PACK B
- BYSANTI TITRATION PACK C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cabometyx

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Calquence

Products Affected

- CALQUENCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Carbaglu

Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use, (A) member has a diagnosis of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) AND Using as adjunctive therapy with other ammonia lowering therapies OR (B) has a diagnosis of chronic hyperammonemia due to the deficiency of the hepatic enzyme NAGS AND Using as maintenance therapy OR (C) Individual is using as adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MA) and using as adjunctive therapy with other ammonia lowering therapies. For Continuation use, there is clinically significant improvement or stabilization in plasma ammonia level.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Cayston

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	7 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cialis BPH

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of benign prostatic hyperplasia (BPH) and is using to treat the signs and symptoms of BPH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial and inadequate response or intolerance to TWO of the following agents: Alfuzosin, Doxazosin, Silodosin, Tamsulosin, or Terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cometriq

Products Affected

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Copiktra

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For continuation, confirmation (verbal or written) of continuing clinical benefit (e.g., complete response, partial response or stable disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Corlanor

Products Affected

- CORLANOR ORAL SOLUTION
- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For dx NYHA class II-IV (Adult) HF, individual is 18 years of age or older. For NYHA class II-IV (Pediatric) HF due to CM, individual is less than 18 years of age.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For INITIAL use: (A) For adult use, Individual is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms AND has a left ventricular ejection fraction less than or equal to 35% AND will be utilizing in combination with a beta-blocker (bisoprolol, carvedilol, metoprolol succinate) OR has a contraindication or intolerance to beta-blocker therapy AND is in normal sinus rhythm AND individual has a resting heart rate greater than or equal to 70 beats per minute. OR (B) For pediatric use, Individual is using for the treatment of New York Heart Association (NYHA) class II, III, or IV heart failure symptoms due to dilated cardiomyopathy AND is in normal sinus rhythm AND individual has an elevated resting heart rate. For Continuation use there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cosentyx

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS
- SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic moderate to severe plaque psoriasis with either of the following: Individual has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as, palms, soles of feet, head/neck, or genitalia). Individual is using for the treatment of Non-radiographic Axial Spondyloarthritis (nr-axSpA) with objective signs of inflammation.
Age Restrictions	For plaque psoriasis, 6 years of age or older. For Enthesitis-Related Arthritis (ERA), 4 years of age or older. For Psoriatic Arthritis, 2 years of age or older. For HS and AS, 12 years of age or older. 18 years of age or older for all other indications.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: moderate to severe Ankylosing Spondylitis (AS), individual had an inadequate response to/intolerant of ONE conventional therapy [such as, NSAIDs or nonbiologic DMARDS such as sulfasalazine OR has a contraindication to NSAIDs or sulfasalazine. For chronic moderate to severe plaque psoriasis (Ps), individual had an inadequate response to/intolerant of phototherapy or other systemic therapy (such as acitretin, cyclosporine or methotrexate) OR has a contraindication to phototherapy, acitretin, cyclosporine, and methotrexate. For Non-radiographic Axial Spondyloarthritis (nr-axSpA), individual has had an inadequate response to, is intolerant of, ONE conventional therapy [such as NSAIDs or nonbiologic DMARDs] (ACR 2019) OR has a contraindication to NSAIDs or DMARDs. For Enthesitis-Related Arthritis (ERA), individual has moderate to severe ERA AND has had an inadequate response to, or is intolerant of, ONE conventional therapy [such as NSAIDs or nonbiologic DMARDs] OR has a contraindication to NSAIDs or sulfasalazine or methotrexate. For HS, individual has had an inadequate response to or is intolerant of conventional therapy (such as oral antibiotics) OR has a contraindication to oral antibiotics. For Continuation use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease AND has been receiving and is maintained on a stable dose of Cosentyx.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For unresectable or metastatic melanoma, Individual is using in combination with Zelboraf (vemurafenib) with or without Tecentriq (atezolizumab).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Cresemba

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual initiated treatment in an inpatient setting and requires continued treatment of invasive aspergillosis or mucormycosis or an organism susceptible to isavuconazonium in an outpatient setting. For invasive aspergillosis individual has an inadequate response/intolerance to or contraindication to voriconazole or liposomal amphotericin B (Patterson 2016). For invasive mucormycosis individual has had an inadequate response/intolerance to or contraindication to amphotericin B (CDC-Mucormycosis). Individual has human immunodeficiency virus (HIV) infection and is using to treat esophageal candidiasis refractory to oral itraconazole and/or fluconazole (AHFS).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Cystagon

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Danziten

Products Affected

- DANZITEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML, Ph status, T315I, Y253H, E255K/V, F359V/C/I or G250E status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daraprim

Products Affected

- *pyrimethamine oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using in combination with leucovorin AND Individual is using to treat toxoplasmosis AND is using in combination with a sulfonamide unless CI or not tolerated.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Darzalex

Products Affected

- DARZALEX FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	Has received treatment with daratumumab or another anti-CD38 agent
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 75 years old or older OR has comorbidities that preclude use of intensive induction chemotherapy.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DHE Nasal Agents

Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to up to TWO of the following oral agents: Almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan OR If oral triptan agents are not acceptable due to concomitant clinical conditions, such as but not limited to the following: (A) Individual is unable to take oral medications due to one of the following: (1) Individual experiences nausea and vomiting due to migraines OR (2) requires a more rapid onset of action due to short aura time period OR (3) cannot swallow tablets and there are no preferred ODT (oral disintegrating tablet) formulations OR (B) individual is unable to tolerate oral triptan therapy OR (C) Individual has history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, and other vascular risk factors or disorders.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Diacomit

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For dx of seizures associated with Dravet Syndrome AND is taking in combination with clobazam AND has responded inadequately to TWO previous antiepileptic drugs (e.g. valproic acid, topiramate, clobazam) (Wirrell 2017, Ziobro 2018).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Diazepam HRM

Products Affected

- DIAZEPAM INTENSOL
- *diazepam oral concentrate*
- *diazepam oral solution 5 mg/5ml*
- *diazepam oral tablet 10 mg, 2 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis (all ages) and One of the following: (1) if over 65 years of age or older, Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] and the physician has indicated the requested medication is not causing adverse effects. OR (2) has a contraindication or has a clinical reason not to use safer alternatives (ABIM Foundation/AGS 2013). Or (3) individual is 6 months to 64 years of age.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dificid

Products Affected

- DIFICID
- *fidaxomicin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 Days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dimethyl Fumarate

Products Affected

- *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Dupixent

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For initial dx of mod-severe asthma. For initial dx of CRSwNP, dx is demonstrated (demo) by (AAO-HNSF 2015): (a) Anterior rhinoscopy or (b) Nasal endoscopy or (c) CT scan. For initial use in atopic derm (AD), has tried ONE of the following and treatment failed to achieve and maintain remission of low or mild disease activity A) Topical calcineurin inhibitors (2 yrs of age or older) OR B) Phototherapy (2 yrs of age or older) (UVB or PUVA) OR C) Non-corticosteroid systemic immunosuppressants (2 yrs of age or older) OR D) has CI to TCI AND Non-corticosteroid systemic immunosuppressants AND unable to use Phototherapy. For initial EoE, mbr has 15 or more intraepithelial eos/hpf (NCT03633617) AND has Symptoms of dysphagia (NCT03633617) AND tried a course of (PPIs) (Hirano,2020) AND tried a course of glucocorticoids (Hirano, 2020). For Initial COPD, mbr has a blood eos count of at least 300 per microliter (Bhatt 2023) AND dx is demo by post-bronchodilator (BD) FEV1/FVC less than 0.7 (Bhatt 2023, GOLD 2024) AND has mod to sev airflow obstruction demo by post-BD FEV1 30-80% predicted normal value AND meets one of the following (Bhatt 2023) (1 or 2): (1) At least one (1) hospitalization or more than 24 hours of medical observation related to COPD in the past twelve (12) months OR (2) In the past 12 months, at least two mod COPD exacerbations and req systemic steroids for at least one exacerbation AND meets one of the following (Bhatt 2023) (A or B): (A) is on a stable dose of LAMA-LABA therapy including inhaled glucocorticoid OR (B) mbr is unable to use an inhaled glucocorticoid due to a medical reason and is on a stable dose of LAMA-LABA therapy. For initial AFRS, dx demonstrated by (AAAAI/ACAAI 2014): (a) IgE mediated inflamm resp to fungal hyphae demonstrated by positive skin testing or fungal-specific IgE in serum AND (b) Presence of nasal polyps AND eosinophilic mucin AND (c) has had recent trial/inadeq resp to maint intranasal CS AND (d) had prior sino-nasal surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial tx of Asthma, (A) mbr has one of the following: (i) has a blood eosinophil count (in the absence of other potential causes of eosinophilia, including HES, neoplastic disease (dz), and known or suspected parasitic infection) greater than or equal to 150 cells/microliter at initiation AND (ii) has had a 3 month trial and inadequate response or intolerance to combo controller therapy (high dose inhaled steroids plus long acting beta2 -agonists, leukotriene modifiers, theophylline or oral steroids) (ERS/ATS 2013). OR (iii) has oral steroid dependent asthma AND (iv) has had a 3 month trial and inadequate response or intolerance to high dose inhaled steroid with daily oral glucocorticoids given in combo with a controller medication (either a long-acting beta2-agonist, or leukotriene receptor antagonist, or theophylline) (ERS/ATS 2013) AND (B) mbr has experienced two or more asthma exacerbations in the prior 12 months req use of a systemic steroid or temp inc in the mbrs usual maint dosage of oral steroids. For cont tx of asthma: (a) mbr has exp one or more of the following: (i) Dec utilization of reliever meds OR (ii) Dec freq of exacerbations (defined as worsening of asthma that req an incr in inhaled steroid dose or tx with systemic steroids) OR (iii) Inc in predicted FEV1 from pretx baseline OR (iv) Reduction in reported asthma-related symptoms, such as, asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing AND continues to use in combination with inhaled corticosteroid-based controller therapy. For initial dx CRSwNP, mbr has had a recent trial and inadequate response to maint intranasal steroid (AAO-HNSF 2015) AND had trial, inadequate response or intolerance to or has CI to the following: (a) Systemic steroids or (b) Sino-nasal surgery AND is using dupilumab as add on therapy to maint intranasal steroid. For initial PN, mbr has dx of PN. For cont use COPD, using in combo with LAMA/LABA therapy OR ICS/LAMA/LABA therapy unless not tolerated AND resulted in clinical improvement in one or more of the following: Dec utilization of reliever medication OR Dec freq or severity of exacerbations OR Reduction in reported COPD-

PA Criteria	Criteria Details
	related symptoms, including SOB, cough, fatigue or sleep disturbance. For cont use for CRSwNP/EoE/PN/AD/CSU/BP/AFRS, imp or stabilization in clinical signs and symptoms of dz. For initial use for CSU, mbr had trial and inadequate response or intolerance to ONE potent antihistamine. For cont use for CSU, cont to use in combo with 2nd gen H1. For initial use in bullous pemphigoid (BP), has had trial and inadequate resp or intol to ONE high-potency topical corticosteroid (CS) or systemic CS (Borradori 2022) AND Dupixent initiated with tapering course of oral CS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Duragesic Patch

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure) AND Individual is not opioid na?ve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic OR (c) already receiving at least 60 mg/day of oral morphine, 30 mg/day of oral oxycodone, 8 mg/day of oral hydromorphone, 60 mg/day of oral hydrocodone or an equianalgesic dose of another opioid. For continued use, (I) individual has a diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (II) diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR (III) Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND prescriber has consulted with individual regarding risks of opioid therapy AND clear treatment goals have been defined and outlined as part of overall pain.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Elidel

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as second-line therapy for mild to moderate atopic dermatitis AND has had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid. OR Use of topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2023, Eleftheriadou 2022): (A). Individual has atopic dermatitis, psoriasis, or vitiligo recalcitrant to topical corticosteroids OR (B) Individual has atopic dermatitis lesions, psoriasis, or vitiligo in sensitive areas (such as face, anogenital area or skin folds) OR (C) Individual has steroid-induced atrophy OR (D) Individual has history of long-term or uninterrupted topical steroid use.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

ELIGARD_GNRH

Products Affected

- ELIGARD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease. OR for castration-resistant disease OR Progressive castration-na?ve disease OR Used as androgen deprivation therapy as a single agent or in combination with antiandrogen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Emsam

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has no known contraindications to the use of a monoamine oxidase inhibitor (MAOI).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Enbrel

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-

INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic moderate to severe plaque psoriasis with either of the following: Individual has greater than or equal to 3% of body surface area with plaque psoriasis OR less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older, except for the diagnosis of JIA and plaque psoriasis. For PsA and JIA, individual is 2 years of age or older. For plaque psoriasis, 4 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Initial use: moderate to severe Ankylosing Spondylitis, individual has had an inadequate response to, or is intolerant of, ONE conventional therapies: [such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine)] (ACR 2019) OR has a contraindication to NSAIDs or sulfasalazine. For Moderate to severe Chronic Plaque Psoriasis, individual has had inadequate response to, or is intolerant of, phototherapy OR ONE other systemic therapies (such as, methotrexate, acitretin, or cyclosporine) has a contraindication to phototherapy, acitretin, cyclosporine, and methotrexate. For moderate to severe Rheumatoid Arthritis, individual has had an inadequate response to, methotrexate titrated to maximally tolerated dose (ACR 2021) OR has a contraindication to methotrexate. For moderate to severe Polyarticular JIA, individual has had an inadequate response to, or is intolerant of, ONE conventional therapy [nonbiologic DMARDs such as methotrexate] (ACR 2019) OR has a contraindication to methotrexate. For Continuation use: there is clinically significant improvement or stabilization in clinical signs and symptoms of the disease AND has been receiving and is maintained on a stable dose of etanercept.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Endari

Products Affected

- *l-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial, individual has a diagnosis of sickle cell anemia defined as the following: (A) Diagnosis of HbSS or HbS/beta0- thalassemia AND (B) At least two episodes of sickle cell crises (SCC) in the last 12 months.
Age Restrictions	Individual is 5 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation, individual experienced a reduction in acute complications of sickle cell disease (e.g. reduction in the number of vaso-occlusive episodes, acute chest syndrome episodes) since initiating Endari (L-glutamine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ensacove

Products Affected

- ENSACOVE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Epclusa

Products Affected

- EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype and positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For tx of seizures associated with Lennox-Gastaut syndrome or Dravet Syndrome, Individual has responded inadequately to two previous antiepileptic drugs (e.g., valproic acid, topiramate, clobazam) (Hancock 2013. Wirrell 2017. Ziobro 2018). Individual is using for tuberous sclerosis complex.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Epogen and Procrit

Products Affected

- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For initial use of EPO: Baseline Hemoglobin (Hgb) levels are less than 10 g/dL AND baseline evaluation of the individual iron status is adequate as defined by one of the following: transferrin saturation 20% or greater OR ferritin 80 ng/mL or greater OR bone marrow demonstrates adequate iron stores. And individual is using for one of the following: For MDS, endogenous EPO level is less than or equal to 500 mU/ml. For anemia related to zidovudine (ZDV) in HIV-infected mbr when the dose of ZDV is less than or equal to 4200 mg per week, endogenous EPO level is less than or equal 500 mU/ml. For tx of anemia due to myelosuppressive chemotherapy known to produce anemia when the following are met: chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For anemia associated with CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10 to 11 g/dL. For anemia associated with CKD NOT ON dialysis, use is to achieve and maintain hgb levels of 10 g/dL. For continued use, mbr demonstrates continued need for ESA tx and has confirmation of response to tx as evidenced by an inc in HGB levels from baseline AND is using the lowest ESA dose necessary to avoid transfusions AND meets one of the following criteria: (a) HGB level is not greater than 11 g/dL for CKD individuals on dialysis, or greater than 10.0 g/dL for CKD non-dialysis, unless otherwise specified (for example, pediatric individuals with CKD where target Hgb levels is within the range of 10 to 12 g/dL) OR (b) HGB is not greater than 11 g/dL for indv using for myelosuppressive chemotherapy related anemia or myelodysplastic syndrome (NCCN) OR HGB level is not greater than 12 g/dL for ZDV-related anemia in patients with HIV AND if using for myelosuppressive chemotherapy-related anemia, individual is not using beyond 6 weeks after chemotherapy has completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Dialysis Dependent use: 1 year. All other use: 6 months.

PA Criteria	Criteria Details
Other Criteria	For ESA use for elective, non-cardiac, non-vascular surgery to reduce the need for allogenic blood transfusions AND Baseline Hgb level is greater than 10 g/dL and less than or equal to 13 g/dL AND is at high risk for perioperative transfusions with significant, anticipated blood loss AND Baseline iron status is adequate as defined by one of the following: (i) Transferrin saturation 20% or greater OR (ii) Ferritin 80 ng/mL or greater OR (iii) Bone marrow demonstrates adequate iron stores.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Eraxis

Products Affected

- ERAXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of Candidemia or certain other forms of Candida infection OR esophageal candidiasis OR member is transitioning from inpatient treatment to an outpatient setting and requires continued therapy for an organism susceptible to anidulafungin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erleada

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR Has had a bilateral orchiectomy. For non-metastatic castration-resistant prostate cancer (nmCRPC), Individual has a PSA doubling time (PSADT) less than or equal to 10 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Erwinase

Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has developed a confirmed (written or verbal) systemic allergic reaction or anaphylaxis to prior treatment with E. Coli-derived asparaginase.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Esbriet

Products Affected

- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial use for Diagnosis of idiopathic pulmonary fibrosis (IPF) demonstrated by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without lung tissue sampling. Individual has pulmonary function tests within prior 60 days demonstrating a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continued use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to decreased frequency of exacerbations, slowed rate of FVC decline or improvement in respiratory symptom burden).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Exjade

Products Affected

- *deferasirox oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

External Insulin Pumps

Products Affected

- OMNIPOD 5 DEXG7G6 INTRO GEN 5
- OMNIPOD 5 DEXG7G6 PODS GEN 5
- OMNIPOD 5 LIBRE INTRO
- OMNIPOD 5 LIBRE PODS
- OMNIPOD CLASSIC PODS (GEN 3)
- OMNIPOD DASH INTRO (GEN 4)
- OMNIPOD DASH PODS (GEN 4)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has diagnosis of diabetes Mellitus (any type). Individual or the individual's caregiver(s) has completed a comprehensive diabetes education program AND requires insulin injections multiple times daily AND requires multiple blood glucose tests/readings daily.
Age Restrictions	Individual is 2 years of age or older for DM1, or is 18 years of age or older for DM2.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Exxua

Products Affected

- EXXUA
- EXXUA TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Fasenra

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use in eosinophilic granulomatosis with polyangiitis (EGPA), individual has a diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA) defined as (Wechsler 2024): (A) A blood eosinophil level of greater than 10% of leukocytes or an absolute eosinophil count of greater than 1000 cells per microliter (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease and known or suspected parasitic infection) AND (B) the presence of two or more features of eosinophilic granulomatosis with polyangiitis (including, a biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatosis inflammation, neuropathy, mono or poly [motor deficit or nerve conduction abnormality], pulmonary infiltrates, non-fixed, sinonasal abnormality, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura, antineutrophil cytoplasmic antibody [ANCA] positive status, MPO or PR3 antibody positive status). For initial use in HES, individual has had trial and inadequate response to oral corticosteroids (WHO 2022 AND has experienced HES flares within the past 12 months requiring escalation in therapy (increase in oral corticosteroid dose or increase/addition of immunosuppressive or cytotoxic therapy) AND has a blood eosinophil count greater than or equal to 1000 cells/microliter.
Age Restrictions	For severe eosinophilic asthma, Individual is 6 years of age or older. For hypereosinophilic syndrome (HES), individual is 12 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA), individual is 18 years of age or older.

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.
Other Criteria	For Initial use in severe eosinophilic asthma, individual has had a 3 month trial and inadequate response or intolerance to combination controller therapy (high dose inhaled corticosteroids plus long acting beta2 agonists, leukotriene modifiers, theophylline or oral corticosteroids) (GINA 2024) AND has experienced two or more asthma exacerbations in the prior 12 months requiring use of a systemic corticosteroid or temporary increase in the individuals usual maintenance dosage of oral corticosteroids (ERS/ATS, 2013) AND has a blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter (150 cells/mm3) at initiation of therapy. For initial use in eosinophilic granulomatosis with polyangiitis (EGPA), individual is using in combination with oral corticosteroid therapy (Wechsler 2024). For Continuation use in severe eosinophilic asthma, treatment has resulted in clinical improvement in one or more of the following: (a) decreased utilization of reliever medication OR (b) decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR (c) increase in percent predicted FEV1 from pretreatment baseline OR (d) reduction in reported asthma-related symptoms, such as, but not limited to asthmatic symptoms upon awakening, coughing, fatigue, shortness of breath, sleep disturbance, or wheezing. AND continues to use benralizumab in combination with inhaled corticosteroid-based controller therapy. For continued use in EGPA, treatment with benralizumab has resulted in clinically significant improvement or stabilization in clinical signs and symptoms of disease. For continued use in HES, treatment with benralizumab has resulted in clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to decrease or absence of HES flares, improvement in fatigue).
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fetzima

Products Affected

- FETZIMA
- FETZIMA TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For MDD, individual has had a trial of TWO of the following: Desvenlafaxine, fluoxetine, fluvoxamine, escitalopram, citalopram, paroxetine, sertraline, mirtazapine, venlafaxine, or bupropion.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fintepla

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss/reduction.
Required Medical Information	Diagnosis: Lennox-Gastaut syndrome (LGS), Dravet Syndrome (DS).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of seizures associated with Lennox-Gastaut syndrome or Dravet Syndrome AND has responded inadequately to two previous antiepileptic drugs (Lagae 2019, Wirrell 2017, Ziobro 2018).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Firazyr

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*
- SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Prophylaxis for HAE attacks.
Required Medical Information	Dx of Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I, Type II or Type III] - Treatment of Acute Attacks. verified by: A) Type I, II confirmed by a C4 level below the lower limit of normal (as defined by laboratory testing) and either a C1 inhibitor antigenic level below the lower limit of normal (as defined by lab testing) or a C1 inhibitor functional level below the lower limit of normal (as defined by the lab testing). OR B) Type III confirmed by normal C1-INH levels as defined by the laboratory testing AND Provider attests that other causes of angioedema have been ruled out
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a history of moderate or severe attacks [type I, II or III] such as airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, or painful facial distortion and using Icatibant for acute HAE attacks.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Firmagon

Products Affected

- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Used for progressive castration-na?ve disease or for castration-resistant disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Forteo

Products Affected

- *teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Osteoporosis is defined as a BMD T-Score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to young adult reference population OR a Clinical diagnosis based on a history of a low trauma fracture (fragility fracture) at high risk for fracture OR associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months) at high risk for fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual meets one of the following: (A) Individual has been refractory to a trial of a oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia. 5. Severe renal insufficiency as defined by creatinine clearance less than 35 mL/min for alendronate agents and zoledronic acid or creatinine clearance less than 30 mL/min for risedronate and ibandronate. OR (C) Individual is a postmenopausal female at very high risk for fracture as defined by one or more of the following (AACE/ACE 2020): Recent fracture (within the past 12 months), Fractures while on approved osteoporosis therapy, Multiple fractures, Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoids), Very low T-score (less than -3.0), High risk for falls or history of injurious falls, or Very high fracture probability by FRAX (fracture risk assessment tool) (e.g. major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or other validated fracture risk algorithm. AND has ONE of the following dx: 1. mbr is a postmenopausal female with a diagnosis of osteoporosis at high for fracture OR 2. Mbr has osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture OR 3. male diagnosed with primary or hypogonadal osteoporosis at high risk for fracture using to inc bone mass. For continued use, there is clinically significant response to therapy (including but not limited to no new fractures reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction) AND IF mbr has been on therapy less than or equal to 24 months of treatment, a repeat BMD demonstrates a stable or increase in BMD.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Fotivda

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For RCC, individual has received at least two prior systemic therapies AND at least one prior systemic therapy included a vascular endothelial growth factor receptor tyrosine kinase inhibitor (VEGFR TKI), such as axitinib, cabozantinib, lenvatinib, sunitinib, or pazopanib (Rini 2020).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Fruzaqla

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Galafold

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, Individual has a diagnosis of Fabry disease as defined with either complete deficiency or less than 5% of mean normal alpha-galactosidase A (a-Gal A) enzyme activity in leukocytes, dried blood spots or serum (plasma) analysis OR galactosidase alpha (GLA) gene mutation by gene sequencing. Individual has an amendable GLA gene variant based on the human embryonic kidney-293 assay.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use, Individual has one or more symptoms or physical findings attributable to Fabry disease (ACMG), such as but not limited to: (a) Burning pain in the extremities (acroparesthesias), or (b) Cutaneous vascular lesions (angiokeratomas), or (c) Corneal verticillata (whorls), or (d) Decreased sweating (anhidrosis or hypohidrosis), or (e) Personal or family history of exercise, heat, or cold intolerance, or (f) Personal or family history of kidney failure. For continued use, Individual has had a positive therapeutic response to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Gattex

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 7 months, Continuation: 1 Year.
Other Criteria	For initial use, in the diagnosis of Short Bowel Syndrome (SBS), individual is dependent on parenteral nutrition (PN) support. For continued use, individual has experienced improvement as compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gavreto

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has written or verbal confirmation of RET fusion (or rearrangement) positive tumors. For NSCLC, individual has not received treatment with another RET rearrangement positive-targeted agent, such as cabozantinib, vandetanib, or selpercatinib (NCT03037385).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gilenya

Products Affected

- *fingolimod hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	I. Individual has had a trial and inadequate response (including but not limited to clinical relapse, new or enlarged lesions on MRI or disability progression) or intolerance to one of the following: Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Glatiramer Acetate/Glatopa, Dimethyl Fumarate, or Teriflunomide OR II. Individual has high disease activity despite treatment with a disease modifying drug (including Aubagio, Avonex, Bafiertam, Extavia, Kesimpta, Plegridy, Ponvory Rebif, Betaseron, Briumvi Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Copaxone/Glatiramer/Glatopa, Tecfidera, Tyruko,Tysabri, Vumerity and Zeposia) OR III. Individual is treatment naive (no previous history of use of disease modifying drugs such as Aubagio, Avonex, Bafiertam, Betaseron, Briumvi, Copaxone/Glatiramer/Glatopa, Extavia, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory Rebif, Tecfidera, Tyruko,Tysabri, Vumerity and Zeposia) AND IV. Individual has rapidly evolving severe relapsing multiple sclerosis OR V. Individual is between 10-17 years of age and has a diagnosis relapsing MS (RMS).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Glatiramer Agents

Products Affected

- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml* MG/ML, 40 MG/ML
- GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gleevec

Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML/ALL Philadelphia chromosome (Ph) status. For Myelodysplastic/Myeloproliferative disorders, (PDGFR) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Gleostine

Products Affected

- *lomustine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLP 1

Products Affected

- *liraglutide*
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG
- RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG
- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Gomekli

Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For neurofibromatosis type 1 (NF1), individual has a Body Surface Area greater than or equal to 0.40 m2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Hadlima

Products Affected

- HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML
- HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) AND agent is used to reduce signs/symptoms OR to induce/maintain clinical response.
Age Restrictions	Individual is 18 years of age or older for all indications except JIA, uveitis, UC, Hidradenitis Suppurativa (HS) and Crohns disease. Individual is 2 years of age or older for JIA and uveitis. Individual is 6 years of age or older for Crohns disease. Individual is 12 years of age or older for HS. Individual is 5 years of age or older for UC.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: For RA, mbr has had an inadequate response to MTX titrated to maximally tolerated dose (ACR 2021) OR has a contraindication (CI) to MTX. Individual has Psoriatic Arthritis (PsA). For Ankylosing Spondylitis (AS), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine) OR has a CI to NSAIDs or sulfasalazine. Individual has Crohn's disease (CD). For plaque psoriasis (Ps), mbr has had an inadequate response to, or is intolerant of, phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and MTX. For Polyarticular Juvenile Idiopathic Arthritis (PJIA), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy [nonbiologic DMARDs (such as methotrexate)] (ACR 2011) OR has a CI to MTX. Individual has Ulcerative Colitis (UC). For uveitis, mbr has chronic, recurrent, treatment-refractory or vision-threatening disease and has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as corticosteroids or immunosuprresants [azathioprine, cyclosporine, or MTX]) OR has a CI to corticosteroids, azathioprine, cyclosporine, and MTX. For chronic, progressive, treatment-refractory Sarcoidosis (Sweiss 2014, DAI 2019), mbr has had an inadequate response to, is intolerant of, or has a CI to systemic corticosteroids AND mbr has had an inadequate response to, or is intolerant of ONE nonbiologic DMARDs (such as methotrexate or azathioprine) OR has a CI to MTX and azathioprine. For Hidradenitis Suppurativa (HS) (Hurley stage II or Hurley stage III disease) AND has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as oral antibiotics) OR has a CI to oral antibiotics. For continued use, there is improvement or stabilization in clinical signs and symptoms of the disease AND has been receiving and is maintained on a stable dose of adalimumab-bwwd.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Hepsera

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	12 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial and inadequate response or intolerance to or has a contraindication to an alternative antiviral agent with a higher genetic barrier to resistance for Hepatitis B [such as entecavir or tenofovir] (AASLD 2016).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Hernexeos

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, HER2 (ERBB2) tyrosine kinase mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *chlordiazepoxide-amitriptyline*
- *clomipramine hcl oral*
- *desipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral solution*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*
- *protriptyline hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HRM Age AU

Products Affected

- BAC (BUTALBITAL-ACETAMIN-CAFF)
- *benztropine mesylate oral*
- BIJUVA
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *carbinoxamine maleate oral solution*
- *chlordiazepoxide-clidinium*
- *chlorzoxazone oral tablet 500 mg*
- *clemastine fumarate oral tablet 2.68 mg*
- CLIMARA PRO
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *cyproheptadine hcl oral syrup*
- *dicyclomine hcl oral capsule*
- *dicyclomine hcl oral solution 10 mg/5ml*
- *dicyclomine hcl oral tablet 20 mg*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *estrogens conjugated*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *meclizine hcl oral tablet 12.5 mg, 25 mg*
- *megestrol acetate oral suspension 625 mg/5ml*
- *meperidine hcl injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine hcl oral solution*
- *meperidine hcl oral tablet 50 mg*
- *meprobamate*
- *methyldopa oral*
- *pentazocine-naloxone hcl*
- PREMARIN ORAL
- *promethazine hcl oral solution*
- *promethazine hcl oral tablet*
- PROMETHEGAN
- *trihexyphenidyl hcl oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) (as identified by American Geriatric Society) for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	Individuals that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 65 years of age or older.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Human Growth Hormone

Products Affected

- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Initial Requests, For idiopathic GHD, has signs/sym of GHD, growth velocity (GV) 2 SD below age-appropriate mean or ht 2.25 SD below age-appropriate mean and A subnormal (SubNL) response (less than 10ng/ml) to 2 GH stimulation tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopituitarism and low GH (less than 10ng/ml) OR 2 other pituitary hormone deficiencies and low IGF-1 OR mbr has cranial irradiation with low IGF1 and normal thyroid tests. Child born small for gestational age (SGA) (birth wt or length 2 or more SD below the mean for gest age), Child fails to manifest catch up growth by age 4 yr (ht 2 or more SD below the mean for age, gender) AND Other causes for short stature have been ruled out. Transitioning adolescent: SMR, Tanner Stage is greater than or equal to 4 AND either of the following: A) GH tx has been stopped for at least a month and the diagnosis of GHD is as follows: 1) idiopathic isolated GHD (SubNL response to 2 GH stim tests OR SubNL response (GH conc of less than 10 ng/mL) to 1 provocative test and low IGF-I/IGFBP-3) OR 2) multiple pituitary hormone deficiency, (SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3 or 3) with cranial irradiation, low IGF with normal thyroid OR B) any of the following: known genetic mutation assoc with def GH production/secretion or Hypothalamic-pit tumor/structural defect or 3 other pit hormone deficiencies. Adult GHD, mbr has GHD in childhood or documented hypopituitarism, hypothalamic disease, surgery, radiation therapy, trauma, or aneurysmal subarachnoid hemorrhage. GHD confirmed/reconfirmed: SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5 ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine) OR SubNL response to 1 stimulation test for adults with hypothalamic or pituitary disease and 1 or more additional pituitary hormone deficiencies OR 3 other pituitary hormone deficiencies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Initial requests for therapy in child: For Reconstructive GH tx, if either ht is at least 2.25 but less than 2.5 SD below the mean for age, gender and GV is less than the 10th percentile over 1 yr OR ht is at least 2.5 SD below the mean for age, gender for conditions known responsive to GH. For Continuation therapy: in child (including reconstructive tx) when the following are met: individual evaluated AND children over 12, either of the following: 1) an X-ray report with evidence that epiphyses have NOT closed OR 2) SMR of less than or equal to 3. Termination for reconstructive use: Evidence of epiphyseal fusion. GH in adults, GHD is verified or reverified as noted above. GH for Adolescents with childhood onset GHD who have prior documented hypopituitarism and a SMR of greater than or equal to 4.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Humira

Products Affected

- HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML
- HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) AND agent is used to reduce signs/symptoms OR to induce/maintain clinical response.
Age Restrictions	Individual is 18 years of age or older for all indications except JIA, uveitis, UC, Hidradenitis Suppurativa (HS) and Crohns disease. Individual is 2 years old for JIA and uveitis. Individual is 6 years of age for Crohns disease. Individual is 12 years old for HS. Individual is 5 years of age or older for UC.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: For RA, mbr has had an inadequate response to MTX titrated to maximally tolerated dose (ACR 2021) OR has a contraindication(CI) to MTX. Individual has Psoriatic Arthritis (PsA). For Ankylosing Spondylitis (AS), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine) OR has a CI to NSAIDs or sulfasalazine. Individual has Crohn's disease (CD). For plaque psoriasis (Ps), mbr has had an inadequate response to, or is intolerant of, phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and MTX. For Polyarticular Juvenile Idiopathic Arthritis (PJIA), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy [nonbologic DMARDs (such as methotrexate)] (ACR 2011) OR has a CI to MTX. Individual has Ulcerative Colitis (UC). For uveitis, mbr has chronic, recurrent, treatment-refractory or vision-threatening disease and has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as corticosteroids or immunosuppressants [azathioprine, cyclosporine, or MTX]) OR has a CI to corticosteroids, azathioprine, cyclosporine, and MTX. For chronic, progressive, treatment-refractory Sarcoidosis (Sweiss 2014, DAI 2019), mbr has had an inadequate response to, is intolerant of, or has a CI to systemic corticosteroids AND mbr has had an inadequate response to, or is intolerant of ONE nonbiologic DMARDs (such as methotrexate or azathioprine) OR has a CI to MTX and azathioprine. For Hidradenitis Suppurativa (HS) (Hurley stage II or Hurley stage III disease) AND has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as oral antibiotics) OR has a CI to oral antibiotics. For continued use, there is clinically significant improvement or stabilization in clinical signs and symptoms of the disease AND has been receiving and is maintained on a stable dose of adalimumab.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Hyrnuo

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, HER2 (ERBB2) tyrosine kinase mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has received prior systemic therapy AND is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ibrance

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, HR status, and HER2 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ibtrozi

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC, individual using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iclusig

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For ALL, Philadelphia chromosome (Ph) status. For CML, T315I status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Idhifa

Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has confirmed (written or verbal attestation) isocitratedehydrogenase-2 (IDH2) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imbruvica

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Imkeldi

Products Affected

- *imkeldi*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML/ALL Philadelphia chromosome (Ph) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial treatment of growth failure associated with severe primary IGF-1 deficiency as defined by: Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND normal or elevated growth hormone levels (greater than 10ng/mL on standard GH stimulation tests) are present OR GH gene deletion who have development of neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Continuation of treatment with Increlex (mecasermin), Final adult height has not been reached.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ingrezza

Products Affected

- INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG
- INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG
- INGREZZA ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use in Tardive dyskinesia confirmed by the following (DSM-5): A) Individual has had a stable (drug, dose) medication exposure (either typical or first generation antipsychotic agents [such as, chlorpromazine, haloperidol, fluphenazine], atypical or second-generation antipsychotic agents [such as, clozapine, risperidone, olanzapine, quetiapine, aripiprazole], or certain dopamine receptor-blocking used in treatment of nausea and gastroparesis [such as prochlorperazine, promethazine, metoclopramide] AND B) Presence of involuntary athetoid or choreiform movements. Diagnosis of chorea associated with Huntington's disease.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For continued use, individual has experienced slowing of disease progression or an improvement in symptoms deemed to be clinically significant by the provider based on stabilization or improvement in Abnormal Involuntary Movement Scale (AIMS) score (for TD) or total maximal chorea score (for Huntington's disease).
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inluriyo

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer, ER , HER2 , ESR1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inlyta

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inqovi

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Inrebic

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Interferons for MS

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Iressa

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of recurrent, advanced, or metastatic Non-small cell lung cancer (NSCLC).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Itovebi

Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer (defined as IHC 0 or 1+, or IHC 2+/ISH-), hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status, and PIK3CA-mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	Individual has progressed during adjuvant endocrine treatment or within 12 months of completing adjuvant endocrine therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ITRACONAZOLE

Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For fingernail/toenail onychomycosis 12 weeks. For all other indications 1 year.
Other Criteria	For second-line non-onychomycosis indications include tinea infections (including, but limited to tinea versicolor, tinea cruris, tinea corporis, tinea pedis, tinea manuum, and tinea capitis) where the individual has had a trial and inadequate response or intolerance to at least one prior topical therapy: ciclopirox, clotrimazole, ketoconazole, econazole, or nystatin. OR Individual is transitioning from inpatient treatment to an outpatient setting and requires continued therapy for an organism susceptible to itraconazole for a non-onychomycosis use.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

IVIG

Products Affected

- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 20 GM/200ML, 5 GM/50ML

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For initial (INIT) Autoimmune (AI) mucocutaneous (MC) blistering dx, when mbr had inadeq response/intolerance/contraindication (CI) to ONE other tx such as steroids/non-steroidal immunosuppressives (ISx). For INIT AI neutropenia, active infection (INF) is excluded as cause. For INIT tx of 1 neurologic DZ: A) Lambert-Eaton myasthenic syndrome when muscle weakness AND dx confirm w/characteristic electrodiagnostic (ED) finding using nerve conduction tests, repetitive nerve stimulation (RNS), exercise testing or single fiber EMG (SFEMG) or presence of AB directed against voltage-gated Ca channels B) For MG and dx confirmed by presence of AB against the ACh receptor or muscle specific TK or characteristic ED findings using RNS or SFEMG AND using for exacerbation or acute MG crisis or short-term therapy as ISx tx is taking effect or MAINT therapy of MG when mbr had inadeq response/intolerance/CI to TWO of the following: Pyridostigmine, steroids OR Non-steroidal ISx. C) CIDP when muscle weakness or sensory dysfx is caused by neuropathy in more than 1 limb and evidence of demyelinating neuropathy confirmed by EFNS/PNS or AAN guidelines or CSF analysis and other polyneuropathies. D) For MMN, dx is confirmed by EFNS/PNS 2010/AANEM 2003 guidelines. E) Stiff-person synd when mbr had inadeq response/intolerance/CI to ONE other treatments such as benzodiazepines or baclofen. For cont use of above dx A-E, clinically/objective sig improvement in neurological sx on phys exam and cont need is shown by clinical effect. For INIT AE, dx is confirmed by specific autoab assoc with AE and Clinical present inc neuro sx (i.e, memory deficits, seizures, movement disorders, speech disturbances, behav changes, or psych symptoms) and Alternative etiologies of encephalitis syndrome have been ruled out, such as infectious etiologies, other neuro disorders, or other AI conditions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Tx of primary humoral immunodeficiency when hx of recurrent sinopulmonary infection (SI) req ABX tx AND lack of/inadeq resp to immunodeficiency AND no evidence of renal and GI as causes of hypogammaglobuninemia (HGG) AND INIT pre-tx serum IgG below the lower limit of age adjusted (adj) lab ref range or more than 2SD below age adj mean OR tx of SAD when hx of recnt SI req ABX tx AND lack of inadeq respond to pneumococcal antigen AND normal conc IgG, IgA, IgM, and IgG OR for SCID when INIT pre-tx total serum IgG below the lower limit of age adj lab ref range or more than 2SD below age adj mean OR CD3+ T cell less than 300 cells/mm3 OR presence of maternal T cells in circulation AND no evid of renal and GI as cause of HGG. OR Use for ONE: A) B-cell CLL w/ hx of recurrent bacterial or active INF not respond to AB therapy and HGG w/ total IgG less than 500mg/dL B) MM with 1) hx of clinically sev INF or active clinically sev INF and HGG or 2) functional IgG less than 400mg/dL C) HIV infected children to prevent opport bacterial infection w/HGG (IgG less than 400mg/dL) or recurrent INF D) PARVO B19 chronic INF and severe anemia assoc w/BM suppression. OR using in context of transplant (TX) for ONE: 1) HSCT 2) Solid organ transplantation (TP) including prior desensitization for TP for suppression of PRA anti-HLA antibody (AB) in ppl with high AB (PRA/cPRA) levels to HLA or in mbr w/hx of high levels of donor-spec AB or TX recip at risk of CMV 3) TX recip exp AB-mediated rej w/donor-spec AB. OR for tx of AI disease (DZ): A) ITP w/active bleed or platelet count less than 30,000 mcL B) Fetal alloimmune TCP w/AB to paternal platelet antigen in maternal serum and ONE: Prev affected pregnancy , family hx of maternofetal alloimmune thrombocytopenia (TCP) or fetal blood sample shows TCP C) Isoimmune hemolytic dx of newborn, tx of sev jaundice D) Dermatomyositis (DMM) or polymyositis when mbr had inadeq response/intolerance/CI to ONE other tx, e.g., corticosteroids, non-steroidal IS agents AND Dx confirmed having at least 4 sx: weak trunk/proximal extremities, high serum CK or aldolase levels, unexplainable muscle pain, EMG

PA Criteria	Criteria Details
	findings, anti-Jo-1 AB, arthralgia/arthritis w/out joint destruction, sign of systemic inflammation, e.g.,fever/elevated CRP high SED rate or inflammation myositis seen on muscle biopsy AND using for DMM and skin lesions present or E) AI Encephalitis (AE), eval for neoplasm associated w/AE. For CONT use of AE/AI MC blistering dx/DMM or polymyositis, is clinically sig improv in symptoms on physical exam and need is demonstrated by clinical effect (i.e, pos response, stable on current dose, or worsening of symp occurs from a dose dec or inc in dose intervals, or prev dc resulted in relapse and Cancer screening continues.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Iwilfin

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jadenu

Products Affected

- *deferasirox oral tablet 90 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For dx non-transfusion-dependent thalassemia (NTDT) syndrome, 10 years of age or older. For dx of chronic iron overload, 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jakafi

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jaypirca

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jideytro

Products Affected

- JIDEYTRO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. Using as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Jynarque

Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For autosomal dominant polycystic kidney disease (ADPKD), individual is at risk of rapidly progressing disease consistent with Mayo class IC, ID or IE (Chebib 2018).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kalydeco

Products Affected

- KALYDECO ORAL PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual has a diagnosis of cystic fibrosis (CF) AND has mutation-positive result in the cystic fibrosis transmembrane conductance regulator (CFTR) gene and the mutation type is provided and responsive to Kaldeco.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in FEV1, decrease in pulmonary exacerbations, improvement in BMI or improvement of respiratory symptoms [cough, sputum production, difficulty breathing]).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kesimpta

Products Affected

- KESIMPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of relapsing multiple sclerosis (RMS) (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kisqali

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For early breast cancer, individual is using for up to 3 years in the absence of disease recurrence or unaccetable toxicity. For advanced, recurrent, unresectable or metastatic breast cancer, individual is one of the following: Male, postmenopausal female, premenopausal treated with ovarian ablation/suppression.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Komzifti

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, NPM1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Korlym

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Cushings has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: 24-hour urinary free cortisol (UFC) test, Dexamethasone suppression test (DST), Late-night salivary cortisol (LNSC) test) that are indicative of a positive test.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.
Other Criteria	Initial therapy: Individual is not a candidate for surgery that is expected to correct the cause of endogenous Cushings Syndrome OR disease persists or recurs following surgery intended to correct the cause of endogenous Cushings Syndrome. For continuation of therapy: Individual continues to meet the initial request approval criteria AND has experienced an improvement in or stabilization of glucose control as assessed by fasting serum glucose test, oral glucose tolerance test or hemoglobin A1c test.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Koselugo

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Krazati

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC and Colon/Rectal cancer, KRAS G12C mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Kuvan

Products Affected

- JAVYGTOR
- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU. For continued use, has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU AND. There is a positive response to therapy as evidenced by reduction in blood PHE levels from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 8 weeks, 1 year for continuation
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lazcluze

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lenvima

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Letairis

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, Individual has diagnosis of Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1. Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units. AND Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Leukine

Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individuals who are at high risk for infection-associated complications demonstrated by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infection, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Adjunctive tx and individual as a high risk for infection-associated complications. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For acute myeloid leukemia and using shortly after completion of induction or repeat induction chemo of AML. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500mm3 or experiencing recurrent/resistant infection. For mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis and autologous transplantation. For acceleration of myeloid reconstitution after autologous or allogenic bone marrow transplantation or peripheral blood progenitor cell transplantation. For delayed neutrophil recovery/graft failure after autologous or allogenic bone marrow transplantation. Used to increase survival in individual exposed to myelosuppressive doses of radiation such as Hematopoietic Syndrome of Acute Radiation Syndrome. For malignant melanoma as an adjuvant treatment following surgery for stage III or IV melanoma in those at high risk for recurrence. For relapsed/refractory high-risk neuroblastoma AND using in combination with Danyelza (naxitamab- gqgk) OR is using in combination with dinutuximab (Unituxin), 13-cis-retinoic acid (i.e. isotretinoin) and with or without interleukin-2 (IL-2) (i.e. aldesleukin) AND achieved a partial response to first-line multi-agent, multi-modality therapy (i.e. induction combination chemotherapy, or myeloablative consolidation chemotherapy followed by autologous stem cell transplant).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidocaine 4

Products Affected

- *lidocaine hcl external solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using for anesthesia of accessible mucous membranes of the oral and nasal cavities and proximal portions of the digestive tract.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidocaine 5

Products Affected

- *lidocaine external ointment 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using for anesthesia of accessible mucous membranes of the oropharynx (such as back of the tongue, soft palate, side and back walls of the throat, and the tonsils) OR is using for relief of pain and itching due to minor cuts, minor scrapes, minor skin irritations, minor burns, and insect bites.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lidoderm Patch

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lifyorli

Products Affected

- LIFYORLI (125 MG DOSE)
- LIFYORLI (150 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Livtencity

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using to treat cytomegalovirus (CMV) infection or disease AND is a hematopoietic stem cell transplant (HSCT) or solid organ transplant (SOT) recipient AND is refractory to treatment with ganciclovir, valganciclovir, cidofovir or foscarnet.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lorbrena

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, ALK status, ROS1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lotronex

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is a Female with Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) defined as including diarrhea and 1 or more of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS. Member is female AND Member has chronic symptoms of IBS that have persisted for 6 months or longer AND does not have an anatomic or biochemical abnormality of the gastrointestinal tract.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a trial and inadequate response or intolerance TWO (2) of the following medications: (a) Loperamide (b) antispasmodics (for example, dicyclomine), or (c) tricyclic antidepressants (AGA 2021).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Lumakras

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC and mCRC, KRAS G12C mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC, individual has confirmed (written or verbal) disease progression after one or more prior lines of systemic therapy and using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Lupron Depot

Products Affected

- *leuprolide acetate (3 month)*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease OR for castration-resistant disease OR progressive castration-naïve disease OR as androgen deprivation therapy as a single agent or in combination with antiandrogen. For Gynecology Uses: Initial treatment/retreatment of endometriosis OR Preoperative treatment as adjunct to surgical treatment of uterine fibroids (leiomyoma uteri), such as but not limited to reducing the size of fibroids to allow for a vaginal procedure, prior to surgical treatment (myomectomy or hysterectomy) in patients with confirmed anemia (Letheby et al. 2001, 2017). To induce amenorrhea in women (such as but not limited to menstruating women diagnosed with severe thrombocytopenia or aplastic anemia). Using for endometrial thinning prior to endometrial ablation for dysfunctional uterine bleeding. For Endocrine Uses: central Precocious puberty, defined as beginning of secondary sexual characteristics before age 8 in girls and before age 9 in boys and dx has been confirmed (written or verbal) by one of the following: pubertal response to a GnRH agonist test OR A pubertal level of:(1) a third generation LH assay OR (2) pediatric LH assay OR (3) ultra-sensitive LH assay OR (4) assay that can detect levels less than 0.2 AND has been confirmed (written or verbal) by assessment of bone age versus chronological age. For Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer): Hormonal therapy for clinical relapse in individuals with stage II-IV granulosa cell tumors or Hormonal therapy as a single agent for persistent disease, clinical relapse, or recurrence.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Gender Dysphoria/incongruence (Coleman 2022) mbr has experienced puberty to at least Tanner stage 2 (Hembree 2017, Coleman 2022)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lupron Kit IR

Products Affected

- *leuprolide acetate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Other advanced, recurrent, or metastatic disease OR for castration-resistant disease OR progressive castration-naïve disease OR as androgen deprivation therapy as a single agent or in combination with antiandrogen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lynparza

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Ovarian, Breast cancer, Prostate, and Pancreatic cancer, BRCA mutation status. For mCRPC, germline or somatic homologous recombination repair (HRR) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Lytgobi

Products Affected

- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For intrahepatic cholangiocarcinoma, FGF/FGFR2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mavyret

Products Affected

- MAVYRET ORAL PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of acute hepatitis C, chronic hepatitis C (CHC) infection, which includes a genotype and a positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Megace Suspension HRM

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for the treatment of cachexia, or unexplained weight loss in individuals with HIV/AIDS. Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Megace Tabs HRM

Products Affected

- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] for individuals greater than 65 and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	Individual has advanced, inoperable, recurrent breast cancer and using for palliative management. Individual has endometrial/uterine cancer and is using for palliative management.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mekinist

Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, NSCLC, ATC, Solid Tumors, and Glioma, BRAF V600 mutation status. For LGG, BRAF V600E mutation status. For cutaneous melanoma, BRAF V600E, V600K mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Mektovi

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma and NSCLC, BRAF V600, V600E/K mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For NSCLC (NCT03915951), individual is treatment naive or had previously treated with 1 prior line of systemic therapy in the advanced/metastatic setting AND has not received prior treatment with any BRAF inhibitor (e.g. dabrafenib, vemurafenib) or MEK inhibitor (cobimetinib, selumetinib).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Mepron

Products Affected

- *atovaquone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Methylphenidate

Products Affected

- *methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 40 mg, 50 mg, 60 mg*
- *methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 36 mg, 54 mg*
- *methylphenidate hcl er oral tablet extended release 20 mg*
- *methylphenidate hcl er(diffus) oral tablet extended release 27 mg, 36 mg, 54 mg*
- *methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD) or Narcolepsy.
Age Restrictions	For ADHD, 6 years of age and older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Modafinil

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Narcolepsy type 1: defined by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following ([1 and 2], OR 3): 1. Clear cataplexy (defined as more than one episode of generally brief) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND 2. Multiple Sleep Latency Test (MSLT) showing one of the following: a. Mean sleep latency of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014) OR b. MSL less than 8min of at least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR 3. Cerebrospinal fluid hypocretin-1 deficiency (less than 100pg/mL or less than one-third of the normative values with the same standardized assay). For Narcolepsy type 2: defined by 1. Multiple sleep latency test (MSLT) with one of the following: a. Mean sleep latency of less than 8 minutes with and evidence of two sleep-onset rapid eye movement periods (SOREMPs) ICSD-3, 2014) OR b. MSL less than 8min of at least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) AND 2. The absence of cataplexy AND 3. Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and Polysomnography.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 Year.
Other Criteria	For obstructive sleep apnea/hypopnea syndrome objectively verified by polysomnography (PSG) or home testing with portable monitor showing one of the following (AASM 2017, ICDSD-3): 1. Greater than 15 obstructive events (defined as apneas, hypopneas plus respiratory event related arousal) per hour of sleep OR 2. Greater than 5 obstructive events per hour of sleep and mbr reports any of the following: a. Unintentional sleep episodes during wakefulness or b. Daytime sleepiness or c. Unrefreshing sleep or d. Fatigue or e. Insomnia or f. Waking up breath holding, gasping or choking or g. Bed partner describing loud snoring, breathing interruptions or both or h. Presence of comorbid conditions including HTN, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, afib or type 2 diabetes mellitus AND 3. Has an Epworth Sleepiness Scale (ESS) score greater than or equal to 10. For Shift-Work Sleep Disorder (SWSD) defined by all of the following: 1. No other medical disorder or mental disorder accounts for the symptoms AND 2. Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag) AND 3. Symptoms have occurred for at least 3 months, AND 4. mbr has one of the following: a. mbr has excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase OR b. Polysomnography demonstrates loss of a normal sleep-wake pattern (such as, disturbed chronobiological rhythmicity). For idiopathic hypersomnia (IH) defined by the following (ICSD-3, Kahn 2015, AASM 2021): 1. Daily periods of irresistible need to sleep or daytime lapses into sleep for more than 3 months AND 2. Absence of cataplexy AND Insufficient sleep syndrome ruled out (if deemed necessary, by lack of improvement of sleepiness after an adequate trial of increased nocturnal time in bed, preferably verified by at least 1 week of wrist actigraphy) AND 3. Multiple Sleep Latency Test (MSLT) shows the following: a. Fewer than 2 sleep-onset rapid eye movement periods (SOREMPs) OR b. No SOREMPs if the REM sleep latency period on the preceding overnight polysomnogram is 15 minutes or less

PA Criteria	Criteria Details
	AND 5. one of the following: a. MSLT showing a mean sleep latency of 8 minutes or less OR b. Total 24-hour sleep time of 660 minutes or longer (typically 12-14 hours) on 24-hour polysomnography monitoring (performed after the correction of chronic sleep deprivation) or by wrist actigraphy in association with a sleep log (averaged over at least 7 days with unrestricted sleep) AND 6. Hypersomnolence or MSLT findings are not better explained by another sleep disorder, medical or neurologic disorder, mental disorder, medication use, or substance abuse. For Renewal: use has resulted in a reduction in frequency of cataplexy attacks compared to baseline OR has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in ESS measurements or Maintenance of Wakefulness Test (MWT) compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Modeyso

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diffuse midline glioma, H3 K27M mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has progressive disease following prior therapy AND using Modeyso (dordaviprone) as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Mounjaro

Products Affected

- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Individual is using for weight loss.
Required Medical Information	Documentation (written) has been provided for diagnosis. Attestation has been provided that diagnosis has been verified by history of: (A) Hemoglobin A1c (A1C) greater than or equal to 6.5% OR (B) Fasting Plasma Glucose (FPG) greater than or equal to 126 mg/dl (after fasting for at least 8 hours) OR (C) 2 hour plasma glucose greater than or equal to 200mg/dl as part of an oral glucose tolerance test (75g oral glucose after fasting for at least 8 hours) OR (D) Symptoms of hyperglycemia (including polyuria, polydipsia, polyphagia) or hyperglycemic crisis and a random plasma glucose greater than or equal to 200 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Type 2 Diabetes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

MSB Antipsychotics

Products Affected

- COBENFY
- COBENFY STARTER PACK
- FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG
- FANAPT TITRATION PACK A
- FANAPT TITRATION PACK B ORAL TABLET
- FANAPT TITRATION PACK C ORAL

TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following generic oral atypical antipsychotic: Aripiprazole, Asenapine tablets, Lurasidone, Olanzapine, Paliperidone ER, Quetiapine IR, Risperidone, or Ziprasidone OR the preferred generics are not FDA approved and do not have an accepted off-label use for the prescribed indication and the non-preferred agent does.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Namenda Line

Products Affected

- *memantine hcl er*
- *memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individuals that are 50 years of age or older are NOT subject to the prior authorization requirements. Prior Authorization applies to individuals that are 49 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of moderate to severe dementia of the Alzheimers type.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nayzilam

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has HER2- overexpressed/amplified confirmed by one of the following: (A) Immunohistochemistry (IHC) is 3+ or (B) In situ hybridization (ISH) positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nexavar

Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Northera

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Continuation: 1 year
Other Criteria	For initial use, individual has had a trial and inadequate response or intolerance to one prior symptomatic nOH pharmacologic therapy (which may include midodrine or fludrocortisone [AHFS]). For continued use, individual has experienced a positive clinical response with droxidopa use (e.g., sustained decrease in dizziness).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Noxafil

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For an individual who requires continued therapy for an organism susceptible to Posaconazole who is transitioning from inpatient treatment to an outpatient setting.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NP CSF SA Agents

Products Affected

- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Febrile neutropenic Individuals who are at high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have risk factors for FN including any of the following: age greater than 65 years, Poor performance status (ECOG status 3-4) or HIV infection (in particular, those with low CD4 counts (less than or eq 450/microL) but chemotherapy still indicated (Lyman 2014), Prior radiation therapy (within previous 1 year) (Terbuch 2018) (Fujiwara 2017) (Shigeta 2015), Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min) , liver dysfunction (liver function tests at least 2x upper limit of normal or bilirubin gr than 2.0 mg/dL) (Lyman 2014) (Aagaard 2018), recent surgery performed as part of cancer management within previous 30 days (not to include a procedure such as port placement, drain placement, IVC filter, etc) (Lyman 2014, Aagaard 2018). History of active infection within previous 60 days(Lyman 2014, Aagaard 2018). Current open wound and chemotherapy cannot be delayed (Lyman 2014, Aagaard 2018).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Individual has had a trial of, intolerance, or contraindication to Zarxio (Filgrastim-sndz). Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Using for adjunctive tx for FN and has been prophylactic therapy with GCSF agent or has not received prophylactic therapy with a GCSF and who are at high risk for infection-associated complications. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for treatment of cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct

PA Criteria	Criteria Details
	to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant. For autologous hematopoietic stem cell (HSC) mobilization as part of the development of an FDA-approved ex vivo gene therapy (e.g. Zynteglo (betibeglogene autotemcel)).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NP IVIG

Products Affected

- BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 5 GM/50ML

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For initial (INIT) Autoimmune (AI) mucocutaneous (MC) blistering dx, when mbr had inadeq response/intolerance/CI to ONE other tx such as steroids/non-steroidal immunosuppressives (ISx). For INIT AI neutropenia, active INF is excluded as cause. For INIT tx of 1 neurologic DZ: A) Lambert-Eaton myasthenic synd when muscle weakness AND dx confirm w/characteristic electrodiagnostic (ED) finding using nerve conduction tests, RNS, exercise testing SFEMG or presence of AB directed against voltage-gated Ca channels B) For MG and dx confirm by presence of AB against the ACh receptor or muscle specific TK or characteristic ED findings using RNS or SFEMG AND using for exacerbation or acute MG crisis or short-term therapy as ISx tx is taking effect or MAINT therapy of MG when mbr had inadeq response/CI to TWO: Pyridostigmine, steroids or Non-steroidal ISx C) CIDP when muscle weakness or sensory dysfx is neuropathy in more than 1 limb and evidence of demyelinating neuropathy confirm by EFNS/PNS or AAN guidelines or CSF analysis and other polyneuropathies D) For MMN, dx is confirm by EFNS/PNS 2010/AANEM 2003 guidelines E) Stiff-person synd when mbr had inadeq response/CI to ONE other txs such as BDZ or baclofen. For cont use of above dx A-E, clinically/objective sig improve in neuro sx on phys exam and cont need is shown by clinical effect. For INIT AE, dx is confirm by specific autoab assoc with AE and Clinical present include neuro sx and Alt etiologies of encephalitis syndrome have been ruled out, such as INF etiologies, other neuro disorders, or other AI conditions. Tx of IgG subclass/specific AB deficiency (SAD) when hx of SI req ABX tx AND lack of inadeq respond to immunization AND nml conc IgG, IgA, IgM, and IgG(SAD). OR for SCID/IgG subclass when INIT pre-tx total serum IgG below lower limit of age adj lab ref range or more than 2SD below age adj mean OR (SCID) CD3+ T cell less than 300 cells/mm3 OR presence of maternal T cells AND no evid of renal and GI as cause of HGG.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Non-preferred (NPF) IG allowed if mbr had trial and inadeq response to 1 preferred (PF) IG (Gammunex/C, Octagam) OR PF IG not FDA/Off-label approved or due to clinical condition such as but not limited to needing IG specific agent w/specific properties: Severe IgA deficiency or deficiency w/AB against IgA requiring agent w/very low IgA content, or Hyper-prolinemia, or documented hypersensitivity (HS) rxn to any ingredient not also present in NPF agent OR documented rxn including but not limited to hemolysis/renal dysfunction that maybe less w/NPF agent w/diff property.Tx of primary humoral immunodeficiency when hx of recurrent sinopulmonary infection (SI) req ABX tx AND lack of/inadeq resp to immunization AND no evidence of renal and GI as causes of hypogammaglobuninemia (HGG) AND INIT pre-tx serum IgG below lower limit of age adjusted (adj) lab ref range or more than 2SD below age adj mean OR Use for ONE: A)B-cell CLL w/hx of recurrent bacterial or active infection (INF) not responding to antimicrobial therapy and HGG w/total IgG less than 500mg/dL B)MM 1) w/hx of active/clinically severe INF and HGG or 2) total IgG less than 400mg/dL C)HIV infected child to prevent opport bacter INF w/HGG (IgG less than 400mg/dL) or recurrent INF D) PARVO B19 chronic INF and sev anemia assoc w/bone marrow suppression OR using in context of transplant (TP) for ONE: 1) HSCT 2) Solid organ TP including prior desensitization for TP for suppression of panel reactive anti-HLA antibody (AB) in ppl w/high panel reactive AB (PRA/corrected PRA) levels to human leukocyte antigens (HLA) or in mbr w/hx of hi levels of donor-spec AB OR TP recipients (TR) at risk of CMV 3)TR experiencing AB-mediated rejection w/donor-spec AB OR for tx of AI disease (DZ): A) ITP w/ active bleed or platelet count less than 30k mcL B) Fetal alloimmune thrombocytopenia (TCP) with AB to paternal platelet antigen in maternal serum and ONE: Prev affected pregnancy, family hx of maternofetal alloimmune TCP or fetal blood sample shows TCP C) Isoimmune hemolytic dx of newborn, tx of severe hyperbilirubinemia D) Dermatomyositis (DMM) or polymyositis

PA Criteria	Criteria Details
	when mbr had inadeq response/intolerance/CI to ONE other tx, e.g. steroids, non-steroidal ISx AND Dx confirmed by presence of at least 4 characteristics: weak trunk/proximal extremities, hi serum CK or aldolase levels, unexplainable muscle pain, EMG findings, anti-Jo-1 AB, arthralgia/arthritis w/out joint destruction, sign of systemic inflammation, e.g.,fever/elevated CRP/high SED rate or inflammation myositis seen on muscle biopsy AND using for DMM and skin lesions present or E) AI Encephalitis (AE), eval for neoplasm assoc w/encephalitis. For CONT use of AE/AI MC blistering dx/DMM or polymyositis, there is clinically sig improv in sx on phys exam and need is demonstrated by clinical effect (i.e, pos response, stable on dose,or worsening of sx occurs from dose dec or inc in dose intervals, or prev discontinuation result in relapse and cancer screening cont.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NP LA Opioid

Products Affected

- *buprenorphine transdermal*
- *methadone hcl oral tablet*
- *morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- *tramadol hcl (er biphasic) oral tablet extended release 24 hour*
- *tramadol hcl er*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months. Maintenance 6 months. Cancer Pain/Terminal Dx or Palliative Care 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use, Individual has one of the following: (a) Diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (b) Diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Individual has one of the following: (a) An inadequate response to ONE alternative treatment options, such as but not limited to non-opioid analgesics and immediate-release opioids OR (b) Alternative treatment options would otherwise be inadequate to provide sufficient management of pain OR (c) Individual has contraindications to non-opioid analgesics (such as NSAID use in individuals with active ulcer condition/gastrointestinal bleeding, renal failure) AND for initial therapy, individual is not opioid na?ve as noted by the following: (a) Individual is currently using a short-acting opioid analgesic, including use of opioid analgesia as an inpatient for post-surgical pain OR (b) Individual is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic. For continued use, (I) individual has a diagnosis of cancer related pain and/or is actively undergoing cancer therapy (provide cancer diagnosis) OR (II) diagnosis of terminal illness and is receiving palliative/end-of-life care (provide terminal diagnosis) OR (III) Individual has pain severe enough to require daily, around-the-clock, long term opioid treatment (provide diagnosis) AND Attestation (verbal or written) that long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline AND Prescriber has consulted individual regarding risks of opioid therapy AND clear treatment goals have been defined and outline as part of overall plan.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NP Pegfilgrastim Agents

Products Affected

- UDENYCA

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Individual has had a trial of, intolerance, or contraindication to Neulasta/Neulasta Onpro (Pegfilgrastim) AND Adjunctive tx of Febrile neutropenia and has not received prophylactic therapy with Pegfilgrastim agents and has high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have risk factors for FN including any of the following: age greater than 65 years, Poor performance status (ECOG status 3-4) or HIV infection (in particular, those with low CD4 counts (less than or eq 450/uL) but chemotherapy still indicated (Lyman 2014), Prior radiation therapy (within previous 1 year) (Terbuch 2018) (Fujiwara 2017) (Shigeta 2015), Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min), liver dysfunction (liver function tests at least 2x upper limit of normal or bilirubin gr than 2.0 mg/dL) (Lyman 2014) (Aagaard 2018), recent surgery performed as part of cancer management within previous 30 days (not to include a procedure such as port placement, drain placement, IVC filter, etc) (Lyman 2014, Aagaard 2018). History of active infection within previous 60 days(Lyman 2014, Aagaard 2018). Current open wound and chemotherapy cannot be delayed (Lyman 2014, Aagaard 2018).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Individual with nonmyeloid malignancy is using for Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. For use after accidental or intentional total body radiation of myelosuppressive doses (greater than 2 Grays [Gy]) (such as Hematopoietic Syndrome of Acute Radiation Syndrome). For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for treatment of cancer. After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution OR when engraftment is delayed or has failed. For autologous hematopoietic stem cell (HSC) mobilization as part of the development of an FDA-approved ex vivo gene therapy (e.g. Zynteglo (betibeglogene autotemcel)).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nubeqa

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Individual has Metastatic castration-sensitive prostate cancer (mCSPC) OR (2) Individual metastatic castration-sensitive prostate cancer (mCSPC) OR (3) Individual has a diagnosis of non-metastatic castration resistant prostate cancer (nmCRPC) AND has a PSA doubling time (PSADT) less than or equal to 10 months AND (4) One of the following: (a) individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (Degarelix] OR (b) Has had a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Nucala

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	For sev eosinophilic asthma: In the absence of other potential causes of eosinophilia, including HES, neoplastic disease and known or suspected parasitic infections, has a blood eosinophil count that is either greater than or equal to 150 cells/mm3 at initiation of therapy. For initial severe eosinophilic asthma, mbr had a 3-mon trial/inadeq response or intolerance to combo controller therapy (high dose inhaled corticosteroids (CS) plus LA beta2-agonist, leukotriene modifiers, long-acting muscarinic antagonists or oral CS) (GINA 2024) AND exp 2 or more asthma exacerbations in past 12 mon requiring use of a systemic CS or temp increase in the mbr usual maint. dose of oral CS (ERS/ATS 2013). For Continuation of w/severe eosinophilic asthma, tx resulted in clinical improv in one or more of the following: i) Decreased utilization of reliever med OR ii) decreased freq of exacerbation (defined as worsening of asthma that requires an inc in inhaled CS dose or tx w/systemic CS) OR iii) increase in percent predicted FEV1 from pretreatment baseline OR iv) A reduction in reported asthma-related sx, including asthmatic sxs upon awakening, coughing, fatigue, SOB, sleep disturbance or wheezing. AND using in combination with inhaled CS-based controller therapy. For initial COPD, with eosinophilic phenotype AND dx is demonstrated by post-bronchodilator FEV1/FVC less than 0.7 AND mbr has mod to sev airflow obstruction demonstrated by post-bronchodilator FEV1 20% to 80% predicted AND currently on LAMA in comb with LABA and ICS AND meets one of the following (1 or 2): 1)Two or more moderate COPD exacerbations in the prior 12 months requiring use of systemic CS or abx OR 2) One or more severe COPD exacerbation in the prior 12 months requiring more than 24 hours hospitalization AND has a blood EOD (in absence of other potential causes of eosinophilia, including HES, neoplastic disease and known or suspected parasitic infection) greater than or equal to 300 cells/mm3.
Age Restrictions	For eosinophilic asthma: 6 years old or older. For eosinophilic granulomatosis with polyangitis (EGPA),chronic rhinosinusitis with nasal polyps (CRSwNP) and COPD: 18 years old or older. For hypereosinophilic syndrome (HES): 12 years old or older.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Initial: 6 months. Continuation: 1 Year.
Other Criteria	For initial EGPA, has been dx for at least 6 months or greater and 1) blood eosinophil level greater than or equal to 10% of leucocytes or AEC of greater than 1000 cells/mm3 (in absence of other potential causes of eosinophilia, including HES, neoplastic dz and known or suspected parasitic INF) and 2) presence of 2 or more features of EGPA (such as, biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil-rich granulomatosis inflamm, neuropathy, mono or poly (motor deficit or nerve conduction abnormality), pulmonary infiltrates, non-fixed, sino-nasal abnormality, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura or antineutrophil cytoplasmic antibody positive status AND 3) mbr is on concurrent oral corticosteroid therapy (Wechsler 2017). For EGPA Continuation, tx has resulted in clinically significant improvement or stabilization in clinical signs and symptoms of disease. For HES, mbr has been dx for at least 6 mon AND had trial/inadeq response to oral corticosteroids AND mbr experienced HES flares w/in the past 12 mon requiring escalation in therapy (increase in oral corticosteroid dose or increase/addition of immunosuppressive or cytotoxic therapy) AND has blood eosinophil count greater than or equal to 1000 cells/mm3. For HES continuation, tx resulted in clinically significant improvement or stabilization in clinical signs/sx of disease (including but not limited to decrease or absence of HES flares, improvement in fatigue). For CRSwNP, there is presence of nasal polyps demonstrated on either a) anterior rhinoscopy OR b) nasal endoscopy OR c) computed tomography AND mbr had trial/inadeq response to MAINT intranasal corticosteroids AND is refractory to or is ineligible or intolerant to systemic corticosteroids OR sinonasal surgery AND mbr is requesting Nucala as add-on therapy to MAINT intranasal corticosteroids. For CRSwNP continuation therapy, tx resulted in clinically significant improvement in clinical signs and sx of disease (including but not limited to improvement in nasal congestion or reduced nasal polyp size) AND continues to use Nucala in combo

PA Criteria	Criteria Details
	w/ MAINT intranasal corticosteroids. For cont COPD, mbr continues to use mepolizumab in combination with ICS/LAMA/LABA therapy AND tx with mepolizumab has resulted in clinical improvement in one or more of the following: 1) Dec utilization of reliever medication OR 2) Dec frequency or severity of exacerbations OR 3) Increase in percent predicted FEV1 from pretreatment baseline OR 4) Reduction in reported COPD-related sx, including SOB, cough, fatigue or sleep disturbance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nuedexta

Products Affected

- *dextromethorphan-quinidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using for the treatment of amyotrophic lateral sclerosis (ALS) (Orphan indication) OR Individual has a diagnosis of pseudobulbar affect (PBA) AND has a concomitant diagnosis with an unrelated neurologic disease or injury [amyotrophic lateral sclerosis (AAN 2020, Pioro et al. 2010), multiple sclerosis (AAN 2019, Pioro et al, 2010), stroke (2016 AHA/ASA)].
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	Initial therapy: Individual has a diagnosis of Parkinsons disease AND Symptoms of psychosis developed after the PD diagnosis AND Symptoms of psychosis include at least one of the following: (1) Visual hallucinations, (2) Auditory hallucination OR (3) Delusions AND Symptoms have been present for at least one month AND Individual has experienced symptoms at least once weekly. Psychiatric symptoms cannot be attributed to disorders such as schizophrenia, schizoaffective disorder, delusional disorder, or mood disorder with psychotic features, or a general medical condition including delirium. For continued therapy, the individual has had a reduction in symptoms of psychosis compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Nurtec

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the acute treatment of migraine headaches, Individual has had a trial of and inadequate response or intolerance to two oral triptans (AHS 2021) OR is unable to tolerate oral triptan therapy OR has one of the following cardiovascular or non- coronary vascular contraindications to use of triptans: (a) Ischemic coronary artery disease (CAD) including angina pectoris, history of myocardial infarction, documented silent ischemia, coronary artery vasospasm (including Prinzmetal?s angina) or (b) History of stroke or transient ischemic attack (TIA) or (c) Peripheral vascular disease or (d) Ischemic bowel disease or (e) Uncontrolled hypertension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year

PA Criteria	Criteria Details
Other Criteria	For initial use in prevention of episodic migraine headaches, mbr has a dx of episodic migraine defined as at least 4 and fewer than 15 migraine days per month and fewer than 15 HA days per month on average during the previous 3 month period (ICHD-3) AND is using agent for migraine prophy. AND If mbr is also currently using botulinum toxin for prophy and is going to be using Nurtec ODT and botulinum toxin together (i.e., not switching from one agent to another), the following must apply: (1) Individual has had a reduction in the overall number of migraine days or reduction in number of severe migraine days per month with botulinum toxin use AND (2) continues to experience a significant number of migraine headache days or severe migraine days per month requiring additional therapy for migraine prevention. For Continued use for migraine prophylaxis, mbr has a reduction in the overall number of migraine days or reduction in number of severe migraine days per month AND has obtained clinical benefit deemed significant by individual or prescriber including any of the following (AHS 2021): (a) 50% reduction in frequency of days with headache or migraine OR (b) Significant decrease in attack duration OR (c) Significant decrease in attack severity OR (d) Improved response to acute treatment OR (e) Reduction in migraine-related disability and improvements in functioning in important areas of life OR (f) Improvements in health related quality of life and reduction in psychological stress due to migraine AND If individual is using concurrently with botulinum toxin for migraine prophylaxis, the following must apply: Individual has had further reduction in the overall number of migraine days or reduction in number of severe migraine days per month compared to monotherapy with botulinum toxin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Octreotide Line

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*
- *octreotide acetate subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of acromegaly has been confirmed by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (such as but not limited to: Insulin-like Growth Factor 1 levels, Oral Glucose Tolerance Test with associated Growth Hormone (GH) levels) that are indicative of a positive test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ofev

Products Affected

- *nintedanib esylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Initial: dx of idiopathic pulmonary fibrosis (IPF) is demonstrated by (Raghu 2018): Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without lung tissue sampling. For dx systemic sclerosis-associated interstitial lung disease (SSc-ILD), individual has pulmonary function tests within prior 60 days demonstrating Forced Vital Capacity (%FVC) greater than or equal to 40%. For dx of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype, progressive disease has been demonstrated by one of the following within the last 24 months while on treatment: (a) FVC decline of greater than or equal to 10% OR (b) 2 of the following: (1) FVC decline greater than or equal to 5% and less than 10% or (2) Worsening respiratory symptoms or (3) Increased fibrosis on HRCT AND individual has pulmonary function tests within prior 60 days demonstrating FVC greater than or equal to 45%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to decreased frequency of exacerbations, slowed rate of FVC decline or improvement in respiratory symptom burden).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ogsiveo

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual has an ECOG performance status of 0-2.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojemda

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For LGG, BRAF fusion or rearrangement, or BRAF V600 mutation status.
Age Restrictions	Individual is 6 months of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ojjaara

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has hemoglobin less than 10 g/dL (NCT04173494, NCT01969838).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Onfi

Products Affected

- *clobazam oral suspension 2.5 mg/ml*
- *clobazam oral tablet 10 mg, 20 mg*
- SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, Prescriber must acknowledge this is a high risk medication (HRM) [as identified by American Geriatric Society] and medication benefits outweigh potential risk for this individual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to ONE of the following preferred agents: Carbamazepine, Clonazepam/ODT, Clorazepate, Diazepam, Divalproex, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine IR, Levetiracetam IR, Oxcarbazepine, Phenytoin, Primidone, Tiagabine, Topiramate IR, Valproate sodium, Valproic acid, Zonisamide OR the preferred agent is not FDA-approved for the prescribed indication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Onureg

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of acute myeloid leukemia (AML), including de novo AML and AML secondary to prior myelodysplastic disease or chronic myelomonocytic leukemia (NCT01757535) AND is used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Opipza

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is: 13 years of age or older for schizophrenia. 6 years of age or older for Tourette's disorder and irritability with autistic disorder. 18 years of age or older for major depressive disorder (MDD).
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For use in schizophrenia, individual has had a trial of and inadequate response or intolerance to ONE of the following generic oral atypical antipsychotics: Aripiprazole, Asenapine tablets, Lurasidone, Olanzapine, Paliperidone ER, Quetiapine IR, Risperidone, Ziprasidone.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Opsumit

Products Affected

- *macitentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, Individual has diagnosis of Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1. Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units. AND Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation therapy, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Orenitram

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, Individual has diagnosis of Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1. Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units. AND Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Orfadin

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, Individuals plasma tyrosine level is maintained below 500 micromol/L to reduce risk of ocular symptoms, developmental delay, or hyperkeratotic plaques.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orgovyx

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, Individual presents with ONE of the following disease state presentations: (a) Evidence of biochemical (PSA) or clinical relapse following local primary intervention with curative intent, such as surgery, radiation therapy, cryotherapy, or high-frequency ultrasound and not a candidate for salvage treatment by surgery OR (b) Newly diagnosed androgen-sensitive metastatic disease OR (c) Advanced localized disease unlikely to be cured by local primary intervention with either surgery or radiation with curative intent. AND is using as androgen deprivation therapy AND is using as a single agent or in combination (excluding those combinations which include fine-particle abiraterone).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For continuation therapy, individual does not show evidence of progressive disease while on therapy AND has serum testosterone level less than 50 ng/dL.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Orkambi

Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual has a diagnosis of cystic fibrosis (CF) AND mutation testing demonstrates the individual has two copies of the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	Individual is 1 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in FEV1, decrease in pulmonary exacerbations, improvement in BMI or improvement of respiratory symptoms [cough, sputum production, difficulty breathing]).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Orserdu

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Otezla

Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK
- OTEZLA XR
- OTEZLA/OTEZLA XR INITIATION PK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pediatric Ps, Individual has chronic moderate to severe (that is, extensive or disabling) plaque Ps with either of the following (AAD 2020): (a) Plaque Ps involving greater than or equal to three percent (3%) body surface area (BSA) OR (b) Plaque Ps involving less than three percent (3%) BSA involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	For pediatric Ps, individual is 6 to 17 years of age. For PsA, individual is 6 years of age or older. All other indications, Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Initial use in: Individual weighing at least 20 kg AND has Psoriatic Arthritis (PsA). For plaque psoriasis (Ps), Individual has had an inadequate response to, or is intolerant of phototherapy or other systemic therapy (such as acitretin, cyclosporine or methotrexate) OR has a contraindication to methotrexate, sulfasalazine, cyclosporine, and leflunomide OR individual had an inadequate response to, or is intolerant of ONE, or has a contraindication to ALL of the following topical therapies for psoriasis (Gold 2022): Medium to high potency topical steroid Tazarotene, Vitamin D analogs (calcitriol, calcipotriene, or calcipotriene/betamethasone combination agents), Topical calcineurin inhibitors (tacrolimus or pimecrolimus), Anthralin. For pediatric Ps, member weighing at least 20 kg AND has had an inadequate response to or is intolerant of phototherapy or other systemic therapy (such as acitretin, cyclosporine, or methotrexate) OR has a contraindication to phototherapy, acitretin, cyclosporine, and methotrexate. For Behcets disease, Individual has had an inadequate response to, or is intolerant of ONE conventional therapy [such as topical or systemic corticosteroid, immunosuppressants, colchicine, or NSAIDs] OR has as contraindication to ALL conventional therapy [corticosteroids, immunosuppressants, colchicine, NSAIDs]. For continuation, individual has been receiving and is maintained on a stable dose of Otezla AND there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Oxervate

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of stage 2 or stage 3 neurotrophic keratitis in one or both eyes, as shown by the presence of one of the following: (A) Persistent epithelial defect(s) OR (B) Corneal ulcer(s).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has evidence of decreased corneal sensitivity in at least one corneal quadrant AND has failed one or more conventional non-surgical treatments for neurotrophic keratitis such as artificial tears, gels, or ointments.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pegfilgrastim Agents

Products Affected

- NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Adjunctive tx of Febrile neutropenia and has not received prophylactic therapy with Pegfilgrastim agents and has high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have risk factors for FN including any of the following: age greater than 65 years, Poor performance status (ECOG status 3-4) or HIV infection (in particular, those with low CD4 counts (less than or eq 450/?L) but chemotherapy still indicated (Lyman 2014), Prior radiation therapy (within previous 1 year) (Terbuch 2018) (Fujiwara 2017) (Shigeta 2015), Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min), liver dysfunction (liver function tests at least 2x upper limit of normal or bilirubin gr than 2.0 mg/dL) (Lyman 2014) (Aagaard 2018), recent surgery performed as part of cancer management within previous 30 days (not to include a procedure such as port placement, drain placement, IVC filter, etc) (Lyman 2014, Aagaard 2018). History of active infection within previous 60 days(Lyman 2014, Aagaard 2018). Current open wound and chemotherapy cannot be delayed (Lyman 2014, Aagaard 2018).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Individual with nonmyeloid malignancy is using for Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. For use after accidental or intentional total body radiation of myelosuppressive doses (greater than 2 Grays [Gy]) (such as Hematopoietic Syndrome of Acute Radiation Syndrome). For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for treatment of cancer. After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution OR when engraftment is delayed or has failed. For autologous hematopoietic stem cell (HSC) mobilization as part of the development of an FDA-approved ex vivo gene therapy (e.g. Zynteglo (betibeglogene autotemcel)).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pemazyre

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual with relapsed or refractory myeloid/lymphoid neoplasms (MLNs) OR unresectable locally advanced, or metastatic cholangiocarcinoma AND using as monotherapy AND has confirmed disease progression (written or verbal) after one or more prior lines of systemic therapy. For metastatic cholangiocarcinoma, FGFR2 mutation status. For MLNs, FGFR1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Phesgo

Products Affected

- PHESGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has HER2-positive breast cancer confirmed (verbal or written) by EITHER immunohistochemistry (IHC) of 3+ OR positive In situ hybridization (ISH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Piqray

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, hormone receptor (HR) status, human epithelial growth factor receptor 2 (HER2) status, and PIK3CA-mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Pomalyst

Products Affected

- *pomalidomide*
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prevymis

Products Affected

- PREVYMIS ORAL PACKET
- PREVYMIS ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For allogeneic hematopoietic stem cell transplant (HSCT) recipient, individual is CMV-seropositive and is using to prevent CMV infection or disease AND therapy will be initiated between Day 0 and Day 28 post-transplantation. For kidney transplant recipient, individual is CMV-seronegative and donor is CMV-seropositive AND is using to prevent CMV disease AND therapy will be initiated between Day 0 and Day 7 post-transplantation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Prolia

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial requests, Osteoporosis is defined as a BMD T-Score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to a young-adult reference population. Glucocorticoid-induced osteoporosis defined as a bone mineral density (BMD) T score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to a young-adult reference population OR a clinical diagnosis based on history of a low trauma fracture (fragility fracture) and is initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5mg or greater of prednisone and expected to remain on glucocorticoids for a least 6 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Initial use: For osteoporosis [in a male or postmenopausal female]/glucocorticoid-induced osteoporosis treatment, individual has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to or has a medical contraindication to other available osteoporosis therapies (such as, bisphosphonates). For male receiving androgen deprivation therapy for non-metastatic prostate cancer, individual has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more additional risk factors for osteoporotic fracture. Individual is a postmenopausal (natural or induced) female receiving adjuvant aromatase inhibitor therapy for the treatment of breast cancer. Individual is a male or postmenopausal female with a diagnosis of osteoporosis based on history of at least one low trauma fracture (fragility fracture). For continuation requests, there is clinically significant response to therapy (including but not limited to confirmation of no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction) AND IF individual has been on therapy greater than or equal to 24 months of treatment, a repeat BMD demonstrates a stable or increase in BMD.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Promacta

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial therapy: 1) Diagnosis of persistent or chronic immune (idiopathic) thrombocytopenia (ITP) AND individual has platelet count of less than 30 x 109/L or active bleeding (ASH, 2011. Hicks et al., 2014) AND has had a prior trial and insufficient response to one of the following: a) corticosteroids OR b) immunoglobulins [for example, intravenous, anti-D] or c) splenectomy OR 2) Diagnosis of severe aplastic anemia AND individual has a platelet count of less than or equal to 30 x 109/L (Olnes et al., 2012.Desmond et al., 2014) AND individual has had a prior trial and insufficient response to an immunosuppressive therapy [such as, anti-thymocte globulin (ATG)] OR 3) individual is using as first-line treatment in combination with standard immunosuppressive therapy 4) Treatment of thrombocytopenia in individual with hepatitis C AND individual has thrombocytopenia that prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. For continuation therapy, for ITP, severe aplastic anemia or therombocytopenia in individuals with Hep C, individual has demonstrated a response to therapy as evidenced by increased platelet counts AND to maintain an adequate platelet count (50 200 x 109/L) to decrease the risk of bleeding OR for MDS, individual has demonstrated a clinically significant response to therapy, such as an increase in platelet counts, decrease in bleeding events, or reduction in need for platelet transfusions .
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Protopic

Products Affected

- *tacrolimus external ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using as second-line therapy for moderate to severe atopic dermatitis AND has had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid. OR Use of topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2023, Eleftheriadou 2022): (A) mbr has atopic dermatitis, psoriasis, or vitiligo recalcitrant to topical corticosteroids OR (B) has atopic dermatitis lesions, psoriasis, or vitiligo in sensitive areas (such as face, anogenital area or skin folds) OR (C) has steroid-induced atrophy OR(D) has history of long-term or uninterrupted topical steroid use.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Purixan

Products Affected

- *mercaptopurine oral suspension*
- PURIXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Qinlock

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent AND has a ECOG performance status of 0-2.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

quinine

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention of nocturnal recumbency leg muscle cramps or other related conditions including but not limited to: Leg cramps, muscle cramps, myoclonus, Periodic Movements of Sleep, Periodic Limb Movements of Sleep (PLMS), Restless Leg Syndrome (RLS).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Individual has been diagnosed with uncomplicated malaria caused by one of the following: Plasmodium falciparum known or suspected to be resistant to chloroquine (CDC) OR chloroquine-resistant Plasmodium vivax (CDC) OR an unidentified plasmodial species known or suspected to be resistant to chloroquine (CDC) OR Chloroquine-resistant Plasmodium ovale (CDC) OR Chloroquine-sensitive Plasmodium malariae (CDC) OR Chloroquine-sensitive Plasmodium knowlesi (CDC) OR Chloroquine- sensitive Plasmodium falciparum, Plasmodium vivax or Plasmodium ovale AND one of the following (CDC): (i.) Individual is pregnant OR (ii.) Chloroquine and hydroxychloroquine are not available. Individual is using as interim treatment for severe malaria until intravenous artesunate is available (AHFS, CDC) or using as follow-on treatment after intravenous artesunate. Individual has a diagnosis of been diagnosed with babesiosis caused by Babesia microti and treatment is in conjunction with intravenous or oral clindamycin (AHFS, DrugPoints B IIa).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rasonque

Products Affected

- RASONQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of metastatic pancreatic adenocarcinoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Repatha

Products Affected

- REPATHA
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Retevmo

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, MTC, Thyroid cancer, Solid Tumors, written or verbal attestation is provided for RET mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revatio

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Individuals requesting for the treatment of erectile dysfunction.
Required Medical Information	For initial requests, individual has diagnosis of Pulmonary Arterial Hypertension in adults World Health Organization (WHO) Group I AND Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units AND Individual has WHO functional class II- IV symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests of PAH for adults, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Revcovi

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADA-SCID is demonstrated by any of the following: (1) Genetic testing revealing biallelic mutations in the ADA1 gene OR (2) Positive newborn screening via T cell receptor excision circles (TRECs) OR (3) Characteristic laboratory findings including but not limited to decreased or absent ADA activity and increase in erythrocyte deoxyadenosine nucleotide (dATP/dAXP) levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use, Revcovi (elapegademase-lvlr) will be used only until definitive therapy with hematopoietic stem cell transplantation (HSCT) OR Individual is not a suitable candidate for HSCT (including but not limited to matched sibling or family donor not available) OR has failed HSCT (Grunebaum 2023). For continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of the disease (Including but not limited to improved or stabilized plasma ADA activity, dAXP levels, total lymphocyte counts, and/or immune function).
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Revlimid

Products Affected

- *lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For MDS, individual has deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR SF3B1 mutation status and thrombocytosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Revuforj

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Leukemia, KMT2A or NPM1 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezdiffra

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has dx of noncirrhotic, non-alcoholic steatohepatitis (or metabolic dysfunction-associated steatohepatitis) (NASH/MASH). Diagnosis is based on One of the following (A or B). (A) Presence of steatosis based on one of the following imaging tests within the past year: (1) FibroScan Vibration-controlled Transient Elastography (VCTE) OR (2) Magnetic Resonance Elastography (MRE) OR (B) Liver biopsy within past 3 years AND NAS score is greater than or equal to 4, and there is a score of at least 1 in two or more of the following NAS components below: (a) Steatosis (b) Hepatocellular ballooning (c) Lobular inflammation AND has fibrosis stage 2 or 3.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	Rezdiffra (resmetirom) is prescribed by, or in consultation with, a hepatologist or gastroenterologist.
Coverage Duration	1 Year.
Other Criteria	For continuation, individual has improvement from baseline in NAFLD Activity Score (NAS) without worsening of fibrosis stage (Harrison 2024/NCT03900429) OR One of the following: (A) has improvement from baseline in fibrosis stage with no worsening of NAS (Harrison 2024/NCT03900429) OR (B) has improvement from baseline in fibrosis stage based on one of the following tests: (1) FibroScan Vibration-controlled Transient Elastography (VCTE) OR (2) Magnetic Resonance Elastography (MRE).

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezlidhia

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, IDH1 mutation status. Individual has an ECOG performance status of 0- 2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as a single agent. For Continued use, there is confirmation of clinically significant improvement (e.g. no disease progression) or stabilization of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rezurock

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For cGVHD after failure of at least two prior lines of systemic therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Rinvoq

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For RA, CD, UC, AS, NR-axSpA, GCA and PsA, individual is 18 years of age or older. For Atopic Dermatitis, individual is 12 years of age or older. For PJIA, individual is 2 years of age or older. For Pediatric PsA, individual is 2 to 17 years of age.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: moderate to severe RA, mbr has had a trial and inadequate response or intolerance to ONE tumor necrosis antagonist agent. For PsA, has had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For pediatric PsA, mbr has had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) agent. For Atopic Dermatitis, a non-corticosteroid systemic immunosuppressant (such as cyclosporine, azathioprine, or mycophenolate mofetil) has failed to achieve and maintain remission of low or mild disease activity state or are CI OR a Biologic therapy (such as dupilumab or tralokinumab) has failed to achieve and maintain remission of low or mild disease activity state or are contraindicated. For UC, individual has had a trial and inadequate response or intolerance to one tumor necrosis factor (TNF) antagonist agents OR If TNF are inadvisable, mbr has had a trial and inadequate response to at least one other approved systemic therapy for UC. For CD, has had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agents OR If TNF antagonists are inadvisable, mbr has had a trial and inadequate response to at least one other approved systemic therapy for CD. For AS, individual has had an inadequate response to, or is intolerant of ONE conventional therapy [such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine)] OR has a CI to NSAIDs or sulfasalazine AND has had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agents. For NR-axSpA, mbr has had an inadequate response to, or is intolerant of ONE conventional therapy [such as NSAIDs or nonbiologic DMARDs] (ACR 2019) OR has a CI to NSAIDs or nonbiologic DMARD. For PJIA, mbr has had an inadequate response to, or is intolerant of ONE conventional therapy [nonbiologic DMARDS (such as methotrexate)] OR has a CI to MTX AND has had a trial and inadequate response or intolerance to ONE TNF antagonist agents. For GCA, upadacitinib used in combination with tapering course of corticosteroids (such
	as prednisone) OR used as a single agent following discontinuation of corticosteroids. Continuation requests, there is improvement or stabilization in clinical signs and symptoms of disease and has been receiving and is maintained on a stable dose of Rinvoq.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Romvimza

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rozlytrek

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ROS1 mutation status. For solid tumor, NTRK gene fusion status.
Age Restrictions	For metastatic non-small cell lung cancer (NSCLC), 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Ovarian cancer and mCRPC, BRCA mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For metastatic castration-resistant prostate cancer (mCRPC), with a deleterious BRCA mutation (germline and/or somatic), Individual had been treated with androgen-receptor directed therapy and a taxane-based chemotherapy AND is using a gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)) concurrently or have had a bilateral orchiectomy and using as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Sabril

Products Affected

- *vigabatrin oral packet*
- *vigabatrin oral tablet*
- VIGADRONE ORAL PACKET
- VIGADRONE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For infantile spasm 1 month to 2yr old. For seizure 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Samsca

Products Affected

- *tolvaptan (hyponatremia) oral tablet 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	30 Days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Scemblix

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CML, Ph status, T315I status.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Selarsdi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older. For Plaque Psoriasis (Ps), Psoriatic Arthritis (PsA), age 6 and older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use: chronic plaque psoriasis (Ps), individual has had an inadequate response to or is intolerant of phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and methotrexate. Individual has psoriatic arthritis (PsA). Individual has Crohns disease (CD). Individual has Ulcerative Colitis (UC). For Continuation use, mbr has been receiving and is maintained on a stable dose of Ustekinumab (or its biosimilar) and there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Signifor IR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Cushings disease has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: 24-hour urinary free cortisol (UFC) test, Dexamethasone suppression test (DST), Late-night salivary cortisol (LNSC) test) that are indicative of a positive test.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Simlandi

Products Affected

- SIMLANDI (1 PEN) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML
- SIMLANDI (1 SYRINGE)
- SIMLANDI (2 PEN)
- SIMLANDI (2 SYRINGE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) AND agent is used to reduce signs/symptoms OR to induce/maintain clinical response.
Age Restrictions	Individual is 18 years of age or older for all indications except JIA, uveitis, UC, Hidradenitis Suppurativa (HS) and Crohns disease. Individual is 2 years of age or older for JIA and uveitis. Individual is 6 years of age or older for Crohns disease. Individual is 12 years of age or older for HS. Individual is 5 years of age or older for UC.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: For RA, mbr has had an inadequate response to MTX titrated to maximally tolerated dose (ACR 2021) OR has a contraindication (CI) to MTX. For Ankylosing Spondylitis (AS), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine) OR has a CI to NSAIDs or sulfasalazine. Individual has Psoriatic Arthritis (PsA). Individual has Crohn's disease (CD). For plaque psoriasis (Ps), mbr has had an inadequate response to, or is intolerant of, phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and MTX. For Polyarticular Juvenile Idiopathic Arthritis (PJIA), mbr has had an inadequate response to, or is intolerant of, ONE conventional therapy [nonbologic DMARDs (such as methotrexate)] (ACR 2011) OR has a CI to MTX. Individual has Ulcerative Colitis (UC). For uveitis, mbr has chronic, recurrent, treatment-refractory or vision-threatening disease and has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as corticosteroids or immunosuppressants [azathioprine, cyclosporine, or MTX]) OR has a CI to corticosteroids, azathioprine, cyclosporine, and MTX. For chronic, progressive, treatment-refractory Sarcoidosis (Sweiss 2014, DAI 2019), mbr has had an inadequate response to, is intolerant of, or has a CI to systemic corticosteroids AND has had an inadequate response to, or is intolerant of ONE nonbiologic DMARDs (such as methotrexate or azathioprine) OR has a CI to MTX and azathioprine. For Hidradenitis Suppurativa (HS) (Hurley stage II or Hurley stage III disease) AND has had an inadequate response to, or is intolerant of, ONE conventional therapy (such as oral antibiotics) OR has a CI to oral antibiotics. For continued use, there is improvement or stabilization in clinical signs and symptoms of the disease AND has been receiving and is maintained on a stable dose of adalimumab-ryvk.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Sirturo

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has a diagnosis of pulmonary multidrug-resistant tuberculosis (MDR-TB) or pulmonary extensively drug-resistant tuberculosis (XDR-TB) or pulmonary pre-extensively drug-resistant tuberculosis (pre-XDR-TB) AND the individual is using in combination with other anti-infectives (WHO 2019).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Skyrizi

Products Affected

- SKYRIZI INTRAVENOUS
- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 55 MG/0.37ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic moderate to severe (that is, extensive or disabling) plaque psoriasis (Ps) with either of the following (AAD 2019): 1. Patient has greater than or equal to 3% body surface area (BSA) with plaque psoriasis OR 2. less than 3% BSA with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	For plaque psoriasis and psoriatic arthritis, individual is 6 years of age or older. For all other indications, individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use: dx of chronic plaque psoriasis (Ps), individual has had an inadequate response to, or is intolerant of phototherapy or any ONE systemic therapy (such as acitretin, cyclosporine, or methotrexate) OR has a contraindication to phototherapy, acitretin, cyclosporine, and methotrexate. Individual is using for moderate to severe Crohns disease (CD) or Ulcerative Colitis (UC). For Continuation use: there is improvement or stabilization in clinical signs and symptoms of disease AND has been receiving and is maintained on a stable dose of Skyrizi.
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Solaraze

Products Affected

- *diclofenac sodium external gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Somavert

Products Affected

- SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of acromegaly has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: Insulin-like Growth Factor 1 levels, Oral Glucose Tolerance Test with associated Growth Hormone (GH) levels) that are indicative of a positive test AND member has had an inadequate response to surgery and/or radiation OR Surgery and/or radiation therapy are not an option.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Soriatane

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe psoriasis, if individual is a female of reproductive age, has met one of the following: (A) Individual is unresponsive to other therapies OR (B) has a clinical condition that contraindicates the use of other treatments.
Age Restrictions	For severe psoriasis, individual is greater than 18 years of age.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Spravato

Products Affected

- SPRAVATO (56 MG DOSE)
- SPRAVATO (84 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial 3 months, continuation 1 year. MDD with acute suicidal ideation or behavior: 1 year

PA Criteria	Criteria Details
Other Criteria	For initial use, individual is using for the tx of depressive sx with major depressive disorder (MDD) with acute suicidal ideation or behavior AND has a dx of MDD without psychotic features according to DSM-5 (Fu 2020, Ionescu 2020) AND is judged to be at risk for suicide by a clinician based on consideration of suicidal behavior, expressed suicidal ideation or overall clinical assessment consistent with significant continuing risk of suicide AND will use Spravato in addition to antidepressant therapy. Individual has been diagnosed with moderate to severe major depressive disorder (TRD) AND had an inadequate response to the maximum tolerated dose of two antidepressant therapies during the current major depressive episode (MDE) as defined by less than 50% reduction in symptom severity using a standard rating scale that reliably measures depressive symptoms AND will use Spravato as monotherapy OR in addition to antidepressant therapy. For continuation (TRD), individual has had at least a 50% reduction in symptoms of treatment resistant moderate to severe depression compared to baseline using a standard rating scale that reliably measures depressive symptoms AND will use Spravato as monotherapy OR in addition to antidepressant therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sprycel

Products Affected

- *dasatinib*
- PHYRAGO

PA Criteria	Criteria Details
Exclusion Criteria	The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	For CML/ALL, Philadelphia chromosome status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Stelara

Products Affected

- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML
- *ustekinumab intravenous*
- *ustekinumab subcutaneous solution*
- *ustekinumab subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia). Individual has had a trial of and has an allergy to an inactive ingredient in Selarsdi (ustekinumab-aekn) [preferred agent] which interferes with the individual's ability to use the product, and the same allergy is not expected with Stelara (ustekinumab) [non-preferred product].
Age Restrictions	Individual is 18 years of age or older. For Plaque Psoriasis (Ps), Psoriatic Arthritis (PsA), age 6 and older. For Ulcerative Colitis (UC) and Crohns disease (CD), age 2 and older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use: chronic plaque psoriasis (Ps), individual has had an inadequate response to or is intolerant of phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and methotrexate. Individual has psoriatic arthritis (PsA). Individual has Crohns disease (CD). Individual has Ulcerative Colitis (UC). For Continuation use, mbr has been receiving and is maintained on a stable dose of Ustekinumab and there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For gastrointestinal stromal tumors (GIST), individual has had progression after monotherapy with imatinib and sunitinib (or ripretinib for patients intolerant to second-line sunitinib)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Sutent

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Symdeko

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual has a diagnosis of cystic fibrosis (CF) AND has a mutation-positive result in the cystic fibrosis transmembrane conductance regulator (CFTR) gene and the mutation type is provided and responsive to Symdeko.
Age Restrictions	Individual is 6 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in FEV1, decrease in pulmonary exacerbations, improvement in BMI or improvement of respiratory symptoms [cough, sputum production, difficulty breathing]).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Symlin

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Type 1 or type 2 diabetes AND taking mealtime insulin therapy AND has failed to achieve glucose control AND HBA1C is less than or equal to 9.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Synarel Nasal Solution

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Central precocious puberty (CPP), defined as the beginning of secondary sexual maturation characteristics before age 8 in girls and before age 9 in boys. Dx of CPP has been confirmed by one of the following: (1) a pubertal response to a gonadotropin hormone (GnRH) agonist test or (2) a pubertal level of a third generation luteinizing hormone (LH) assay or (3) a pubertal level of a pediatric luteinizing hormone (LH) assay or (4) a pubertal level of an ultra-sensitive luteinizing hormone (LH) assay or (5) a pubertal level on a luteinizing hormone (LH) assay that can detect levels less than 0.2 AND assessment of bone age versus chronological age.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Endometriosis: 6 months, all other indications: 1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Syprine

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of Wilsons Disease as confirmed by two of the following (AASLD 2022): (A) Serum ceruloplasmin less than 20 mg/Dl (B) Presence of Kayser-Fleischer rings (C) 24-hour urinary copper is greater than 40 mcg/day (D) Liver biopsy findings consistent with Wilsons Disease (E) Genetic testing findings consistent with Wilsons Disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tabrecta

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For recurrent, advanced or metastatic non-small cell lung cancer (NSCLC), Individual has mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors AND individual has not received treatment with another MET exon 14 skipping-targeted agent, such as crizotinib. For metastatic NSCLC, individual has MET exon 14 skipping positive tumors. For advanced or metastatic NSCLC, individual has high level MET amplification (greater than or equal to 10 gene copies) (Wolf 2020).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is using Tabrecta (capmatinib) as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tafinlar

Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, NSCLC, ATC, Solid Tumors, LGG, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Takhzyro

Products Affected

- TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hereditary angioedema (HAE) [Type I, Type II or Type III] is verified by: A) a C4 level below the lower limit of normal as defined by laboratory test AND ANY of the following: (i) C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by lab test (ii) C1-INH functional level below the lower limit of normal as defined by lab test or (iii) Presence of a known HAE-causing C1-INH mutation OR B) Type III confirmed by normal C1-INH levels as defined by the laboratory testing AND Provider attests that other causes of angioedema have been ruled out
Age Restrictions	Individual is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial: 8 months, Continuation: 1 Year.
Other Criteria	Individual has a history of moderate or severe attacks [type I, II or III] and is using as prophylaxis against acute attacks of hereditary angioedema for short-term use prior to surgery, dental procedures, or intubation OR for long-term prophylaxis to minimize the frequency and/or severity of recurrent attacks. For continued use in prophylactic care individual has had a positive clinical response defined as a clinically significant reduction in the number and/or frequency of HAE attacks occurred.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Talzenna

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer BRCA mutation status. For mCRPC, HRR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	For mCRPC, individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tarceva

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR-sensitizing mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Targretin

Products Affected

- *bexarotene external*
- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tasigna

Products Affected

- *nilotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tasmar

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use, using in combination with carbidopa/levodopa. For continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tazorac

Products Affected

- *tazarotene external cream*
- *tazarotene external gel*

PA Criteria	Criteria Details
Exclusion Criteria	May not be approved for cosmetic purposes such as, but not limited to the following: Cosmetic purposes, Photoaging, Wrinkles, Hyperpigmentation, Sun damage, or Melasma.
Required Medical Information	For psoriasis, individual has up to 20% of body surface area involvement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For psoriasis, individual has had a prior trial and inadequate response to either of the following (AAD 2009): Any two (2) topical corticosteroids or any one (1) topical corticosteroids plus calcipotriene. For psoriasis use greater than 1 year, efficacy must be documented for continued use. Documentation may include chart notes, consultation notes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Tecentriq Hybreza

Products Affected

- TECENTRIQ HYBREZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, BRAF V600 mutation status. For metastatic NSCLC, molecular markers such as EGFR/ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For metastatic NSCLC, unresectable or metastatic alveolar soft part sarcoma, individual is using as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tecvayli

Products Affected

- TECVAYLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tepmetko

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, mesenchymal-epithelial transition (MET) exon 14 skipping alterations status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For recurrent, advanced, or metastatic Non-Small Cell Lung Cancer (NSCLC), individual is using as monotherapy AND has not received treatment with another MET exon 14 skipping-targeted agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Teriflunomide Agents

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Thalomid

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, Cholangiocarcinoma, and MDS, IDH1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Topical Acyclovir

Products Affected

- *acyclovir external ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For limited non-life-threatening mucocutaneous herpes simplex virus infection in an immunocompromised individual OR for genital herpes infection, individual has had a trial and inadequate response or intolerance to one of the following oral antiviral agent (CDC 2021): Acyclovir, Valacyclovir, or Famciclovir.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Topical Androgens

Products Affected

- *testosterone transdermal gel 1.62 %, 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For primary or hypogonadotropic hypogonadism, individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Initial use: Individual has a dx of (1) primary hypogonadism (congenital or acquired) [for example, Cryptorchidism OR Bilateral torsion OR orchitis OR Vanishing testis syndrome OR Orchiectomy OR Klinefelter Syndrome OR Chemotherapy OR Toxic damage from alcohol or heavy metals OR idiopathic primary hypogonadism]. Or (2) Hypogonadotropic hypogonadism (congenital or acquired) [for example, Idiopathic luteinizing hormone-releasing hormone (LHRH deficiency), OR Pituitary-hypothalamic injury.] Individual is using for a diagnosis of gender Dysphoria/incongruence (Coleman 2022) AND has experienced puberty to at least Tanner Stage 2. For continuation use for primary or hypogonadotropic hypogonadism, Individual meets all criteria for initial therapy AND has had serum testosterone level measured in the previous 180 days AND Individual has obtained clinical benefits as noted by symptom improvement.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Topical Onychomycosis

Products Affected

- JUBLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a confirmed fungal infection (i.e. physical exam). And has confirmed laboratory evidence of one of the following: (1) Trichophyton rubrum OR (2) Trichophyton mentagrophytes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial of and inadequate response or intolerance to oral itraconazole and terbinafine. Or has a, contraindication, drug interaction or concomitant clinical condition (such as but not limited history of liver disease or concerns over hepatotoxicity, history of CHF) which make use of oral itraconazole and terbinafine unacceptable OR Individual has used requested medication within the previous 6 months.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Topical Tretinoin Agents

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Exclusion Criteria	Topical tretinoin agents may not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, Melasma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tracleer

Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, Individual has a right heart catheterization showing all of the following: (a) Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mm Hg at rest (b) Pulmonary capillary wedge pressure (PCWP), mean pulmonary artery wedge pressure (PAWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (c) Pulmonary vascular resistance (PVR) greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has Pulmonary Arterial Hypertension (WHO Group I), and WHO Functional Class II-IV symptoms. For continuation therapy, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Trelstar Line

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7/Gleason grade group 2-3, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tremfya

Products Affected

- TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR
- TREMFYA PEN
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TREMFYA-CD/UC INDUCTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic moderate to severe (that is, extensive or disabling) plaque psoriasis(Ps) with either of the following (AAD 2019): Patient has greater than or equal to 3% of body surface area (BSA) with plaque psoriasis OR less than 3% BSA with plaque psoriasis involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	For Ps and PsA, individual is 6 years of age. All other indications, Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use: Individual weighing at least 40 kg AND has dx of chronic plaque psoriasis (Ps), individual has had an inadequate response to, or is intolerant of, phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporine) OR has a contraindication to phototherapy, acitretin, cyclosporine, and methotrexate. Individual weighing at least 40 kg AND has dx of moderate to severe Psoriatic Arthritis (PsA). For initial use in moderate to severe Crohn's disease (CD) or Ulcerative colitis (UC). For Continuation use: there is clinically significant improvement or stabilization in clinical signs and symptoms of disease AND has been receiving and is maintained on a stable dose of Tremfya.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Trikafta

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK
- TRIKAFTA ORAL THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual has a diagnosis of cystic fibrosis (CF) AND has a mutation-positive result in the cystic fibrosis transmembrane conductance regulator (CFTR) gene and the mutation type is provided and responsive to Trikafta OR has at least one variant in the CFTR gene that results in production of CFTR protein.
Age Restrictions	Individual is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in FEV1, decrease in pulmonary exacerbations, improvement in BMI or improvement of respiratory symptoms [cough, sputum production, difficulty breathing]).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

Truqap

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is HR positive, HER2 negative breast cancer (defined as IHC 0 or 1 plus or IHC 2 plus/ISH negative) and PIK3CA, AKT1, PTEN mutation status. For prostate cancer, PTEN status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For breast cancer, using in combination with Fulvestrant. Meets one of the following: (1) Individual has progressed on at least one endocrine-based regimen in the metastatic setting AND (2) has had progression with at least one cyclin-dependant kinase (CDK) 4/6 inhibitor in the metastatic stetting OR (3) has had a recurrence on or within 12 months of completing adjuvant therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tukysa

Products Affected

- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HER2-positive (HER2+) breast cancer is confirmed by one of the following: (a) Immunohistochemistry (IHC) is 3 + or (b) In situ hybridization (ISH) positive. For HER2-positive (HER2+) breast cancer, RAS wild -type HER2-positive (HER2+) unresectable or metastatic colorectal cancer, including Appendiceal Adenocarcinoma or Biliary Tract Cancers, HER2 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Turalio

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tyenne

Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older. For CRS, JIA, PJIA patient is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Initial use: rheumatoid arthritis (RA), mbr has had an inadequate response to MTX titrated to maximally tolerated dose (ACR 2021) OR has a contraindication to methotrexate, AND mbr has had a trial and inadequate response or intolerance to: Humira(adalimumab) OR Enbrel(etanercept) OR the PF TNF agents are not acceptable due to Individual's age OR has either concomitant clinical condition: (a) Demyelinating disease or (b)Heart failure with documented left ventricular dysfunction. Individual has diagnosis of Still's dz (Adult-onset Still's Disease [AOSD] or Systemic Juvenile Idiopathic Arthritis [SJIA]). For Polyarticular Juvenile Idiopathic Arthritis (PJIA), Individual has had inadequate response to, is intolerant of, ONE Conventional therapy [non-biologic DMARD (such as methotrexate)] OR has contraindication to MTX AND mbr has had a trial and inadequate response or intolerance to: Humira(adalimumab) OR Enbrel(etanercept) OR has either concomitant clinical condition: (a) Demyelinating disease or (b)Heart failure with documented left ventricular dysfunction. For Giant Cell Arteritis, used in combination with a tapering course of corticosteroids (such as, prednisone) OR being used as a single agent after discontinuing corticosteroids. For CRS, individual has a dx of autologous T cell immunotherapy related CRS AND has acute lymphocytic leukemia and is using tocilizumab-aazg for severe blinatumomab- induced CRS. For Continuation use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease and is receiving and maintained on stable dose of tocilizumab-aazg.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Tykerb

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cancer has been confirmed HER2 positive. HER 2 overexpression confirmed (written or verbal) by one of the following: (a) Immunohistochemistry (IHC) 3+ or (b) In situ hybridization (ISH) positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, Individual is a postmenopausal female or a male using to increase bone density with one of the following: (A) dx of osteoporosis (defined as a bone mineral density [BMD] T-score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 as compared to a young-adult reference population) OR (B) clinical dx based on history of A low trauma fracture (fragility fracture) at high risk for fracture AND Individual meets one of the following: (a) refractory to a trial of bisphosphonate OR (b) individual is intolerant to or has a contraindication to bisphosphonate therapy as defined by one of the following (1 through 5): (1) Hypersensitivity to TWO bisphosphonates (one of which must be generic alendronate) OR (2) Inability to stand or sit upright for at least 30 minutes OR(3) A pre-existing gastrointestinal disorder (for example, Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.) OR (4) Uncorrected hypocalcemia OR (5) Severe renal insufficiency as defined by creatinine clearance less than 35 mL/min for alendronate agents and zoledronic agents or creatinine clearance less than 30 mL/min for risedronate and ibandronate. Or (c) Individual is at very high risk for fracture as defined by one or more of the following (AACE/ACE 2020): Recent fracture (within the past 12 months), Fractures while on approved osteoporosis therapy, Multiple fractures, Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoids), Very low T-score (less than -3.0), High risk for falls or history of injurious falls, Very high fracture probability by FRAX (fracture risk assessment tool) (e.g. major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or other validated fracture risk algorithm.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation therapy, there is clinically significant response to therapy (including but not limited to no new fractures or reduction of fractures, or no worsening vertebral fractures, or no clinically significant adverse reaction) AND if individual has been on therapy greater than or equal to 24 months of treatment, a repeat BMD demonstrates a stable or increase in BMD.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Ubrelvy

Products Affected

- UBRELVY ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual has had a trial/inadequate response or intolerance to 2 oral triptans (AHS 2021) OR Individual has one of the following CV or non-coronary vascular contraindications to use of triptans: Ischemic coronary artery disease (CAD) including angina pectoris, history of MI, documented silent ischemia, coronary artery vasospasm (including Prinzmetal?s angina), history of stroke or TIA, PVD, ischemic bowel disease, or uncontrolled hypertension.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Uceris

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vanflyta

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 internal tandem duplication (ITD)-positive mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vaxchora

Products Affected

- VAXCHORA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Vaccine is being used for active immunization against disease caused by vibrio cholerae serogroup 01. Individual is traveling to a cholera affected area.
Age Restrictions	Ages 2 through 64 years of age.
Prescriber Restrictions	
Coverage Duration	3 Months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Venclexta

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Veppanu

Products Affected

- VEPPANU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer, ER, HER2, ESR1 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Verquvo

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, individual has experienced one of the following: (A) Heart failure hospitalization within 6 months OR (B) Use of intravenous outpatient diuretics within 3 months AND Individual will be taking Verquvo (vericiguat) in combination with the following (Armstrong 2020): (A) Entresto (sacubitril/valsartan), angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) unless contraindicated or not tolerated AND (B) Beta-blocker (bisoprolol, carvedilol, metoprolol succinate) unless contraindicated or not tolerated.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Continuation, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in heart failure symptoms, reduction in heart failure related physical limitations, reduction in hospitalizations) AND continues to use Verquvo (vericiguat) in combination with Entresto (sacubitril/valsartan), angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) unless contraindicated or not tolerated AND continues to use Verquvo (vericiguat) in combination with beta-blocker (bisoprolol, carvedilol, metoprolol succinate) therapy unless contraindicated or not tolerated.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Breast cancer, HR status and HER2 status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For early Breast Cancer, individual is only using Verzenio in this combination for a total of 24 months (2 years)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vfend

Products Affected

- *voriconazole intravenous solution reconstituted*
- *voriconazole oral suspension reconstituted*
- *voriconazole oral tablet 200 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is currently transitioning from inpatient treatment (hospital/medical facility) to an outpatient (home) setting and requires continued therapy for an organism susceptible to Vfend (voriconazole). Or mbr is using for a FDA approved use or supported by CMS approved compendia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vitrakvi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Vitrakvi (larotrectinib) oral solution requests, individual is unable to swallow the oral capsule dose form due to a clinical condition, but not limited to the following: (a) Dysphagia OR (b) individual?s age.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vizimpro

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, EGFR mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vonjo

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Voranigo

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Astrocytoma, Oligodendroglioma, IDH1/IDH2 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is using Voranigo (vorasidenib) as a single agent.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a genotype and positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy AND Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.

PA Criteria	Criteria Details
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. For Genotype 1, 1a, Individual has had a trial of and inadequate response to Harvoni (sofosbuvir/ledipasvir) OR Individual is currently on and completing a course of therapy with Vosevi OR has one of the following: (1) Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Harvoni(sofosbuvir/ledipasvir) which is not also in Vosevi OR (2) concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens OR (3) Individual failed to achieve a sustained viral response (SVR) or relapsed after achieving a SVR during a prior successfully completed Hepatitis C regimen containing an NS5A inhibitor OR (4) Individual has unique disease characteristic to which the preferred regimen(s) is not recommended (examples include specific genotype subtype, resistance-associated substitution (RAS) or polymorphism) . For Genotype 4, Individual has had a trial of and inadequate response to Harvoni(sofosbuvir/ledipasvir) or Epclusa(sofosbuvir/velpatasvir) OR Individual is currently on and completing a course of therapy with Vosevi OR has one of the following: (1) Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Harvoni(sofosbuvir/ledipasvir) or Epclusa(sofosbuvir/velpatasvir) which is not also in Vosevi OR (2) concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens OR (3) Individual failed to achieve a sustained viral response (SVR) or relapsed after achieving a SVR during a prior successfully completed Hepatitis C regimen containing an NS5A inhibitor OR (4) Individual has a unique disease characteristic to which the preferred regimen(s) is not recommended (examples include specific genotype subtype, resistance-associated substitution (RAS) or polymorphism).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VOTRIENT

Products Affected

- *pazopanib hcl oral tablet 200 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Vowst

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has had at least three episodes of Clostridiodes difficile infection (initial episode and two recurrences) treated with antibiotic therapy (including Dificid, metronidazole or oral vancomycin) (IDSA/SHEA 2021) AND Current episode of Clostridiodes difficile infection has been verified (written or verbal) with a positive stool test for Clostridiodes difficile toxin AND treatment will be initiated within 2 to 4 days of completing antibiotic treatment for the current Clostridiodes difficile infection episode.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Month.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Welireg

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of VHL is confirmed (written or verbal) by genetic testing demonstrating germline VHL alteration (NCT03401788).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Using Welireg (belzutifan) as monotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Winrevair

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, Individual has a right heart catheterization showing all of the following: (a) Pulmonary capillary wedge pressure (PCWP) or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg (b) Pulmonary vascular resistance (PVR) greater than 5 Wood units. Individual has a platelet count greater than or equal to 50,000/mm3. And individual is using as add-on therapy to be used in combination with other pulmonary arterial hypertension agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Individual has Pulmonary Arterial Hypertension (WHO) Group I, and WHO Functional Class II or III symptoms. Individual is currently receiving two or more pulmonary arterial hypertension agents from two or more different drug classes [phosphodiesterase-5 (PDE-5) inhibitors, endothelin receptor antagonists (ERA), soluble guanylate cyclase stimulators, prostacyclin receptor agonists, prostacyclin analogs] (Chin 2024). For continuation therapy, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in walk distance, dyspnea and/or functional class) AND is using Winrevair as add-on therapy in combination with other pulmonary arterial hypertension agents and has platelet count greater than or equal to 50,000/mm3.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xalkori

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK or ROS1 mutation status. For ALCL and IMT, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xdemvy

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Demodex blepharitis.
Age Restrictions	
Prescriber Restrictions	Xdemvy (lotilaner ophthalmic solution) is prescribed by or in consultation with an optometrist or ophthalmologist.
Coverage Duration	6 Months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xeljanz

Products Affected

- *tofacitinib citrate er*
- *tofacitinib citrate oral solution*
- *tofacitinib citrate oral tablet*
- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	For AS, UC, RA, individual is 18 years of age or older. For PsA, PJIA, individual is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For Initial use: RA, Individual had an inadequate response to MTX titrated to maximally tolerated dose (ACR 2021) OR has a contraindication to methotrexate AND had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For PsA, Individual had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For UC, Individual had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For PJIA, Individual has had an inadequate response to, or is intolerant of, ONE conventional therapy [nonbiologic DMARDS (such as methotrexate)] OR has a contraindication to methotrexate AND had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For Ankylosing Spondylitis (AS), Individual has had an inadequate response to, or is intolerant of, ONE conventional therapy [such as NSAIDs or nonbiologic DMARDs (such as sulfasalazine)] OR has a contraindication to NSAIDs or sulfasalazine AND had a trial and inadequate response or intolerance to ONE tumor necrosis factor (TNF) antagonist agent. For Continuation use, there is clinically significant improvement or stabilization in clinical signs and symptoms of disease AND has been receiving and is maintained on a stable dose of tofacitinib agents.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continuation requests, individual has experienced an improvement in symptoms deemed to be clinically significant by the provider, and if using for Huntingtons disease, there is stabilization or improvement in total maximal chorea score.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Continuation: 1 year
Other Criteria	For initial therapy: Individual is using in combination with somatostatin analog (SSA) therapy (such as but not limited to, lanreotide (Somatuline Depot), octreotide (Sandostatin)) AND individual has had an inadequate response on a stable dose of SSA monotherapy for at least 3 months. For continuation therapy requests: Individual has previously met the initiation criteria AND if improvements are confirmed after 12 weeks of treatment with Xermelo (telotristat ethyl) when added to SSA therapy AND Individual does not report severe constipation or severe persistent or worsening abdominal pain.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Skeletally mature adolescent is defined by at least one mature long bone [for example, closed epiphyseal growth plate of the humerus]. Hypercalcemia of malignancy is defined as an albumin corrected serum calcium level greater than 12.5 mg/dL (3.1 mmol/L).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For Hypercalcemia of malignancy, Refractory to recent (within the last 30 days) treatment with intravenous bisphosphonate therapy (for example, pamidronate, zoledronic acid.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xifaxan - HE

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For the treatment of small intestinal bacterial overgrowth (ACG 2020).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xifaxan 200mg

Products Affected

- XIFAXAN ORAL TABLET 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 Days.
Other Criteria	For 200mg strength, travelers diarrhea (TD), individual has already been started on the requested agent and needs to complete treatment OR Individual has had a trial and inadequate response or intolerance to one of the following agents (1 or 2) or has contraindications to all of the following agents (both 1 and 2) (CDC, 2024): (1) Generic Fluoroquinolone (ciprofloxacin, levofloxacin or ofloxacin) OR (2) Azithromycin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

Xolair

Products Affected

- XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML
- XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML
- XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has Moderate to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND individual has a pretreatment FEV1 less than 80% predicted AND IgE level is equal to or greater than 30 IU/ml. For nasal polyps, individual had an inadequate response to nasal corticosteroids as add-on maintenance treatment AND individual has a serum IgE level greater than or equal to 30 IU/mL. For IgE mediated food allergy, diagnosis is confirmed via clinical hx of IgE mediated food allergy demonstrated by moderate to severe symptoms (including but not limited to throat tightness, dyspnea/wheezing, clinically signification hypotension, generalized urticaria) or requiring administration of epinephrine or emergency medical care AND positive skin prick test or positive serum IgE test or positive food challenge AND has a serum Immunoglobulin E (IgE) level equal to or greater than 30 IU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Continuation: 1 Year.

PA Criteria	Criteria Details
Other Criteria	Initial Treatment: For moderate to severe persistent asthma, individual has had a minimum of 3 month trial and inadequate response or intolerance to ONE combination controller therapy (high dose of inhaled corticosteroids plus long-acting beta-2 agonists, Leukotriene modifiers, theophylline or oral corticosteroids)(GINA 2024). Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement by one or more of the following: Decreased utilization of reliever medication OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1 from pretreatment baseline OR Reduction in reported asthma- related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening. AND continues to use omalizumab in combination with inhaled corticosteroid-based controller therapy. For chronic spontaneous urticaria, individual has had trial and inadequate response or intolerance to ONE potent antihistamine (AAAAI/ACAAI 2014). For continued use for CSU, treatment has resulted in clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to itch severity and hive count). For initial request for CRSwNP, the presence of nasal polyps have been demonstrated on one of the following (AAO-HNS2015): a) anterior rhinoscopy b) nasal endoscopy OR c) computed tomography AND individual has had trial and inadequate response to maintenance intranasal corticosteroids AND individual is refractory to or is ineligible or intolerant to the following (AAAAI/ACAAI 2014): a) systemic corticosteroids OR b) sinonasal surgery. For CRSwNP continuation requests, tx with Xolair has resulted clinically significant improvement in clinical signs and symptoms of disease (including but not limited to improvement in nasal congestion or reduced polyp size) AND continues to use Xolair in combo with maintenance intranasal corticosteroids. For
	initial and continued use for IgE mediated food allergy, individual will use omalizumab in combination with food allergen avoidance AND has a prescription for an auto-injectable epinephrine agent.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 mutation status.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xpovio

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xtandi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Xyrem

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial tx of Narcolepsy type 1 (narcolepsy with cataplexy) defined by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following (ICSD-3): (1) Clear cataplexy (defined as more than one episode of generally brief [less than 2 min]) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND (2) Multiple Sleep Latency Test (MSLT) showing one of the following: (a) MSLT of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) or (b) MSLT of less than 8 minutes with evidence of at least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR (3) Cerebrospinal fluid hypocretin-1 deficiency (less than 100 pg/mL or less than one-third of the normative values with the same standardized assay).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Continuation: 6 months

PA Criteria	Criteria Details
Other Criteria	For initial tx, of Narcolepsy type 2 (narcolepsy without cataplexy) defined by the following: (1) Daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months AND (2) MSLT with one of the following: (a) MSLT of less than 8 minutes and evidence of two SOREMPs (ICSD-3, 2014) or (b) MSLT of less than 8 minutes with evidence of at least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight PSG AND (3) absence of cataplexy AND (4) Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and PSG. AND (5) Mbr has had a previous trial of and inadequate response or intolerance to TWO of the following medications: (A) One of the following wakefulness promoting medications: (i) Modafinil or (ii) Nuvigil (armodafinil) AND (B) One of the following stimulants (for those age 18 and older): (i) Methylphenidate (ii) Dextroamphetamine or (iii) Amphetamine/dextroamphetamine salt immediate-release OR (6) Trials of wakefulness promoting agents and stimulant agents are not acceptable due to concomitant clinical situations including but not limited to the following: (1) Cardiovascular disease or (2) Drug interactions. Mbr has idiopathic hypersomnia defined by (1) daily periods of strong need to sleep or daytime lapses into sleep for more than 3 mon. (2) absence of cataplexy (3) Insuff sleep syndrome ruled out (if nec, by lack of improvement of sleepiness after adequate trial of increased nocturnal time in bed, preferably verified by at least 1 wk. of wrist actigraphy) (4) MSLT shows fewer than 2 SOREMPs OR No SOREMPs if the REM sleep latency period on the preceding overnights polysomnogram is 15min or less (5) The presence of at least one: MSLT shows mean sleep latency of 8 min or less OR total 24hr sleep time of 660 min or longer (typically 12-14 hrs) on 24-hr polysonography monitoring (performed after the correction of chronic sleep deprivation) or by wrist actigraphy in assoc with a sleep log (avg over at least 7 days with unrestricted sleep) AND (6) hypersomolence or MSLT findings are not better explained by another sleep disorder, medical or

PA Criteria	Criteria Details
	neurologic disorder, mental disorder, med use or substance abuse. For continuation, use has resulted in a reduction in frequency of cataplexy attacks compared to baseline OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT) compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Yesintek

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than or equal to 3% of body surface area with plaque psoriasis OR Less than 3% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Individual is 18 years of age or older. For Plaque Psoriasis (Ps), Psoriatic Arthritis (PsA), age 6 and older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For initial use: chronic plaque psoriasis (Ps), individual has had an inadequate response to or is intolerant of phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporine) OR has a CI to phototherapy, acitretin, cyclosporine, and methotrexate. Individual has psoriatic arthritis (PsA). Individual has Crohns disease (CD). Individual has Ulcerative Colitis (UC). For Continuation use, mbr has been receiving and is maintained on a stable dose of Ustekinumab and there is clinically significant improvement or stabilization in clinical signs and symptoms of disease.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Zarxio

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Febrile neutropenic Individuals who are at high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Pneumonia or other clinically documented infections, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Prior episode of febrile neutropenia, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have risk factors for FN including any of the following: age greater than 65 years, Poor performance status (ECOG status 3-4) or HIV infection (in particular, those with low CD4 counts (less than or eq 450/?L) but chemotherapy still indicated (Lyman 2014), Prior radiation therapy (within previous 1 year) (Terbuch 2018) (Fujiwara 2017) (Shigeta 2015), Bone marrow involvement by tumor producing cytopenias, persistent neutropenia (ANC less than 1500mm3), poor renal function (GFR less than 60mL/min) , liver dysfunction (liver function tests at least 2x upper limit of normal or bilirubin gr than 2.0 mg/dL) (Lyman 2014) (Aagaard 2018), recent surgery performed as part of cancer management within previous 30 days (not to include a procedure such as port placement, drain placement, IVC filter, etc) (Lyman 2014, Aagaard 2018). History of active infection within previous 60 days(Lyman 2014, Aagaard 2018). Current open wound and chemotherapy cannot be delayed (Lyman 2014, Aagaard 2018).

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Using for adjunctive tx for FN and has been prophylactic therapy with GCSF or has not received prophylactic therapy with a GCSF and who are at high risk for infection-associated complications. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For myelodysplastic syndrome with ring sideroblasts (MDS-RS) or MDS/MPN-RS-T and using in combination with luspatercept-aamt. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for treatment of cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for collection by

PA Criteria	Criteria Details
	leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant. For tx for hematopoietic cell mobilization in combination with plerixafor. For Wilms Tumor (Nephroblastoma) and using with Regimen M and Regimen I for one of the following courses: Cyclophosphamide and etoposide OR Cyclophosphamide, doxorubicin, and vincristine. For autologous hematopoietic stem cell (HSC) mobilization as part of the development of an FDA-approved ex vivo gene therapy (e.g. Zynteglo (betibeglogene autotemcel)). For hematopoietic cell mobilization for autologous donors in combination with motixafortide.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zavesca

Products Affected

- *miglustat*
- YARGESA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use, presence of type 1 Gaucher disease is verified by either of the following (Weinreb et al. 2004, Wang et al. 2011): Deficiency in Glucocerebrosidase enzyme activity as measured in white blood cells or skin fibroblasts, OR genotype testing indicating mutation of two alleles of the glucocerebrosidase genome. And patient has clinically significant manifestations of gauchers disease including any of the following: skeletal disease (including but not limited to avascular necrosis, Erlenmeyer flask deformity, osteopenia or pathological fracture) OR patient presents with at least 2 of the following: clinically significant hepatomegaly, clinically significant splenomegaly, hgb at least 1 gram per deciliter below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3. For initial use in Niemann-Pick disease type C (NPC) (Geberhiwot 2018), NPC1 or NPC2 mutation status AND individual is experiencing mild or moderate neurological signs of NPC (including but not limited to hypotonia, dystonia, ataxia, dysarthria, dysphagia, developmental delay) and requesting miglustat for the treatment of neurological disease manifestations.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.

PA Criteria	Criteria Details
Other Criteria	For initial use in type 1 Gaucher disease, enzyme replacement therapy with Cerezyme, ELELYSO and VPRIV is not a therapeutic option for reasons including but limited to any of the following (Label, Weinreb et al. 2005): (a) Medically unmanageable hypersensitivity or (b) Development of therapy limiting inhibitory antibodies or (c) Poor peripheral or central venous access. For continued use in type 1 Gaucher disease, there is disease stabilization OR clinically significant improvement in clinical signs and symptoms of disease (including but not limited to reduction of spleen volume, reduction of liver volume, resolution of anemia, resolution of thrombocytopenia, reduction in fatigue, improvement in skeletal manifestations). For continued use in NPC (Geberhiwot 2018), NPC1 or NPC2 mutation status AND there is disease stabilization OR clinically significant improvement or stabilization in clinical signs and symptoms of disease (including but not limited to improvement in ambulation, speech, swallow or fine motor skills).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zejula

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For ovarian cancer, HRD status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Melanoma, and ECD, BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zenbexus

Products Affected

- ZENBEXUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ztalmy

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial use in seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) AND Individual's diagnosis of CDD has been confirmed by genetic testing.
Age Restrictions	Individual is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	For continued use, there is confirmation of clinically significant [including but not limited to a reduction in seizures associated with cyclin-dependent kinase-like (CDKL5) deficiency disorder (CDD)] response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zurzuvae

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. Individual is 12 months postpartum or less AND has a diagnosis of postpartum depression consistent with a qualifying score using a standardized screening tool for depression (such as, but not limited to, Hamilton Rating Scale for Depression [HAM-D], Patient Health Questionnaire [PHQ-9], Beck Depression Inventory [BDI], Montgomery-Asberg Depression Rating Scale [MADRS], Edinburgh Postnatal Depression Scale [EPDS]).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zykadia

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, ALK mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zytiga

Products Affected

- *abiraterone acetate oral tablet 250 mg, 500 mg*
- ABIRTEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Individual is concomitantly receiving a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Zyvox

Products Affected

- *linezolid oral suspension reconstituted*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	vancomycin-resistant enterococcus faecium (VRE) infection OR methicillin-resistant S. aureus (MRSA) infection. Or Infection that is caused by other susceptible gram-positive organisms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days. 1 year for MDR-TB, XDR-TB, non-tuberculous mycobacterial infection.
Other Criteria	If individual started treatment with Linezolid in the hospital and requires continued outpatient therapy for an organism susceptible to linezolid. For diagnosis of pulmonary multidrug-resistant tuberculosis (MDR-TB) or pulmonary extensively drug-resistant tuberculosis (XDR-TB) (WHO 2019), linezolid will be used in combination with other anti-infectives (WHO 2019). For non-tuberculous mycobacterial infection (including but not limited to M. fortuitum) (ATS/ERS/ESCMID/IDSA 2020) AND will be used in combination with other anti-infectives (ATS/ERS/ESCMID/IDSA 2020).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes