ABIRATERONE

Products Affected

- Abiraterone Acetate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC) OR metastatic high-risk castration-sensitive prostate cancer (CSPC). Abiraterone will be used in combination with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ACTEMRA SC

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), Humira (adalimumab), or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.
Age Restrictions	N/A
Prescriber Restrictions	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	Plan year

Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Documentation of positive clinical response to therapy.

ACTHAR

Products Affected

- Acthar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Receipt of live or live attenuated vaccines within 6 weeks of H.P. Acthar Gel, suspected congenital infection (infants), scleroderma, osteoporosis, systemic fungal infection, peptic ulcer disease, ocular herpes simplex, congestive heart failure, recent surgery, uncontrolled hypertension, known hypersensitivity to porcine proteins, primary adrenocortical insufficiency or hyperfunction.
Required Medical Information	For the following diagnoses, patient must have an inadequate response to a trial of parenteral corticosteroids: 1) For rheumatic diseases (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): H.P. Acthar gel must be used as adjunctive treatment, 2) For nephrotic syndrome: H.P. Acthar gel must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): H.P. Acthar gel is being used for MS exacerbation, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic disorders (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic disorders, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness.
Age Restrictions	For infantile spasms: patient is 2 years of age or younger.
Prescriber Restrictions	N/A
Coverage Duration	IS: 12 months. Collagen and ophthalmic diseases, nephrotic syndrome: 6 months. Others: 1 month
Other Criteria	Part B before Part D Step Therapy.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of either episodic migraines or chronic migraines. For episodic migraine, patient must have both of the following: less than 15 headache days per month and 4-14 migraine days per month. For chronic migraine, patient must have both of the following: at least 15 headache days per month and at least 8 migraine days per month. Patient has had a trial and failure or contraindication to at least 2 different preventative migraine medications.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist
Coverage Duration	Initial: 3 months. Renewal: plan year.
Other Criteria	For renewal, patient must have a positive clinical response.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with anaplastic lymphoma kinase (ALK) positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ALPHA1 PROTEINASE INHIBITOR

Products Affected

- Aralast Np INJ 1000MG, 500MG
- Glassia
- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of clinically evident emphysema and severe hereditary deficiency of alpha1-antitrypsin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AMBRISENTAN

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy
Required Medical Information	Patient has a diagnosis of pulmonary arterial hypertension (WHO Group I). For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AUBAGIO

Products Affected

- Aubagio
- Teriflunomide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe hepatic impairment. Pregnancy. Concomitant use with leflunomide.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Serum transaminase and bilirubin levels must be drawn within 6 months prior to initiation of therapy with teriflunomide. For female patients of childbearing potential: Pregnancy was excluded prior to initiation of therapy and patient will use reliable contraception during treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Auryxia will not be approved for a diagnosis of iron deficiency anemia.
Required Medical Information	Patient has a diagnosis of hyperphosphatemia. Patient has chronic kidney disease and is on dialysis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. Concomitant tetrabenazine (Xenazine).
Required Medical Information	Patient has a diagnosis of chorea associated with Huntington's disease OR has a diagnosis of tardive dyskinesia clinically diagnosed with all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has unresectable or metastatic gastrointestinal stromal tumors (GIST) with a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Patient has a diagnosis of advanced systemic mastocytosis including patients with agressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, and mast cell leukemia AND patient has a platelet count greater than 50,000/mm3.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic urothelial carcinoma. The patient has susceptible FGFR3 or FGFR2 genetic alterations and has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe active CNS lupus, or use of Benlysta in combination with other biologics, including B-cell targeted therapies or intravenous (IV) cyclophosphamide
Required Medical Information	Patient has active, autoantibody-positive systemic lupus erythematosus (SLE) and is receiving standard therapy (corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or is not on standard therapy due to past trial and inadequate response or intolerance. Patient has a diagnosis of active lupus nephritis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of polycythemia vera.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BEXAROTENE

Products Affected

- Bexarotene CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of cutaneous T-cell lymphoma and is refractory to at least 1 prior systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BOSENTAN

Products Affected

- Bosentan
- Tracleer TBSO

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN).
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment
Age Restrictions	Age 3 and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of chronic (newly diagnosed or previously treated), accelerated, or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML). For a diagnosis of accelerated phase or blast phase, patient had resistance or intolerance to prior treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BPH VS ED

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not covered for the treatment of Erectile Dysfunction. Maximum dose: 5mg daily
Required Medical Information	Patient must have a diagnosis of BPH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BRAFTOVI

Products Affected

- Braftovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of unresectable or metastatic melanoma: patient has a BRAF V600E or V600K mutation, will be used in combination with binimetinib (Mektovi), patient was not previously treated with a BRAF inhibitor or MEK inhibitor. For a diagnosis of metastatic colorectal cancer: patient has a BRAF V600E mutation, will be used in combination with cetuximab, patient has been on prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of mantle cell lymphoma and has received at least 1 prior therapy. Patient has a diagnosis of Waldenstrom's macroglobulinemia (WM). Patient has a diagnosis of relapsed or refractory marginal zone lymphoma (MZL) and has received at least one anti-CD20-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma (RCC) and meets one of the following: will be used as monotherapy OR will be used in combination with nivolumab for first-line treatment. Patient has a diagnosis of advanced hepatocellular carcinoma and has been previously treated with sorafenib. Patient has a diagnosis of differentiated thyroid cancer that is locally advanced or metastatic and has progressed following prior VEGFR- targeted therapy and is radioactive iodine-refractory or ineligible.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of mantle cell lymphoma and has had at least 1 prior treatment, chronic lymphocytic leukemia (CLL), or small lymphocytic lymphoma (SLL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient has congenital long QT syndrome.
Required Medical Information	Patient has a diagnosis of symptomatic or progressive medullary thyroid cancer. Patient has unresectable locally advanced or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of a bile acid synthesis disorder due to single enzyme defects (SEDs) OR Cholbam is being used as an adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients with manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a hepatologist or gastroenterologist.
Coverage Duration	Plan year
Other Criteria	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of hereditary angioedema.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist or another physician that specializes in the treatment of hereditary angioedema
Coverage Duration	Plan year
Other Criteria	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of progressive, metastatic, medullary thyroid cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of chronic lymphocytic leukemia or small lymphocytic lymphoma. Patient has had at least two prior therapies. Prophylaxis for Pneumocystis jirovecii (PJP) will be provided during treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

COSENTYX

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Plan year
Other Criteria	PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active

	(swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Cobimetinib will be used in combination with vemurafenib (Zelboraf).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CYLTEZO

Products Affected

- Cyltezo
- Cyltezo Starter Package For Crohns Disease/uc/hs
- Cyltezo Starter Package For Psoriasis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PsO (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by

	or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	Plan year
Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Hidradenitis suppurativa (HS), Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values

	[platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min) and/or history of seizures.
Required Medical Information	Patient must have the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine. Patient has a diagnosis of multiple sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must experience improvement in walking speed or other objective measure of walking ability since starting dalfampridine. Dalfampridine at doses exceeding 10mg twice daily are not covered.

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of acute myeloid leukemia (AML) and is newly diagnosed. Daurismo (glasdegib) will be used in combination with low-dose cytarabine. Patient is 75 years old or older OR has comorbidities that precludes the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DEFERASIROX

Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients with an eGFR less than 40mL/min/1.73m2. Patient's with a platelet count less than 50 million/L.
Required Medical Information	(1) For chronic iron overload due to blood transfusions, Diagnosis of chronic iron overload due to blood transfusions and current serum ferritin level greater than 1000 mcg/L. (2) For iron overload in patients with NON-transfusion-dependent thalassemia (NTDT), a) Diagnosis of a NON-transfusion thalassemia syndrome and chronic iron overload, b)For initiation: i) pretreatment LIC of at least 5 mg per gram of dry weight and ii) pretreatment serum ferritin levels greater than 300 mcg/L and iii) For patients currently on deferasirox therapy: current LIC is greater than 3 mg per gram of dry weight or deferasirox will be withheld until the LIC reaches above 5 mg per gram of dry weight.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DEFERIPRONE

Products Affected

- Deferiprone
- Ferriprox SOLN
- Ferriprox Twice-a-day

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of transfusion-related iron overload due to thalassemia syndromes or a diagnosis of sickle cell anemia or other anemias.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of seizures associated with Dravet syndrome. Patient will be on stiripentol with clobazam.
Age Restrictions	Patient is 6 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DICLOFENAC

Products Affected

- Diclofenac Sodium GEL 3%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of actinic keratosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Atopic dermatitis (AD) (init): Diagnosis (dx) of mod to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (eg, prednisone) within the past 12 mo, 2) Prior asthma-related hospitalization within the past 12 mo. One of the following: a) TF/C/I to Fasenra (benralizumab), Nucala (mepolizumab), or Cinqair (reslizumab) or b) For continuation of prior therapy. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Patient is currently dependent on oral corticosteroids for the treatment of asthma. EA, CDA (init): Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller medication [e.g., leukotriene receptor antagonist (eg, montelukast), long-acting beta-2 agonist (LABA) (eg, salmeterol), tiotropium], OR b) One max-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)].
Age Restrictions	Asthma (initial): Patient is 6 years of age or older. AD: Patient is 6 months of age or older. CRSwNP: no age restriction.
Prescriber Restrictions	Atopic dermatitis (Initial): Prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist. Asthma (initial, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (initial, reauth): Prescribed by or in

	consultation with an otolaryngologist, allergist/immunologist, or pulmonologist.
Coverage Duration	Plan year
Other Criteria	Chronic rhinosinusitis with nasal polyposis (CRSwNP) (initial): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. AD (reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. EA (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications). CDA (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, reduction in oral corticosteroid dose). EA, CDA (reauth): Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS, 0-8 scale], improvement in nasal congestion/obstruction score [NC, 0-3 scale]). Used in combination with another agent for CRSwNP.

ENBREL

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally indicated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally indicated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR plamoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, meloxicam, naproxen) at maximally indicated doses.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plan year
Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the

	total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.

EPCLUSA

Products Affected

- Epclusa
- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex (TSC).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan year
Other Criteria	N/A

EPKINLY

Products Affected

- Epkinly

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EPOETIN

Products Affected

- Procrit
- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Determine if ESRD (B vs D) Patient has one of the following diagnosis: anemia associated with chronic renal failure, anemia associated with chemotherapy, Anemia secondary to zidovudine in HIV-infected patients, Reduction of allogeneic RBC transfusion in patients undergoing elective, non cardiac, non vascular surgery
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic basal cell carcinoma OR has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has non-metastatic, castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer. Patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ERLOTINIB

Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pancreatic cancer: Used first-line in locally advanced, unresectable, or metastatic cancer in combination with gemcitabine. For metastatic non-small cell lung cancer: not used in combination with platinum-based chemotherapy, tumors have EGFR exon 19 deletions or exon 21 substitution mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet CAPS
- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of idiopathic pulmonary fibrosis. Liver function tests were performed prior to starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Plan year
Other Criteria	For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.

EVEROLIMUS

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of progressive pancreatic neuroendocrine tumors (pNET) that are unresectable OR progressive, well-differentiated, nonfunctional GI or lung endocrine tumors in patients with unresectable, locally advanced or metastatic disease OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of tuberous sclerosis complex (TSC)-associated partial-onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of recent myocardial infarction or unstable angina, QTcF greater than 450 msec or significant baseline ST-segment or T-wave abnormalities.
Required Medical Information	Patient must have multiple myeloma and received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Must be used in combination with bortezomib and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewals: Patient must have clinical benefit. Patient must not have experienced unresolved severe or medically significant toxicity. Total treatment duration will not exceed 16 cycles (48 weeks).

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has severe asthma with an eosinophilic phenotype. Patient is maintained with high dose inhaled corticosteroid or with medium to high dosed inhaled corticosteroid with a long-acting beta agonist (LABA). Patient has had at least two exacerbations in the past year or at least one exacerbation in the prior year while on daily oral corticosteroid treatment.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of seizures associated with Dravet syndrome and Lennox-Gastaut syndrome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Plan year
Other Criteria	N/A

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC). Patient has tried at least 2 prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months.
Age Restrictions	N/A
Prescriber Restrictions	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy.

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic RET fusion-positive non-small cell lung cancer (NSCLC). Patient has a diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer. Patient has a diagnosis of advanced or metastatic RET fusion positive thyroid cancer and is radioactive iodine-refractory (if radioactive iodine is appropriate).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GILENYA

Products Affected

- Fingolimod
- Gilenya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of previously untreated metastatic non-small cell lung cancer (NSCLC) with tumors expressing non-resistant epidermal growth factor receptor mutations. OR Patient has a diagnosis of metastatic squamous NSCLC and has been previously treated with platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Omnitrope
- Zomacton

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	For CRI: patient is not post-kidney transplant. For TS: diagnosis confirmed by karyotyping. For PWS: diagnosis confirmed by genetic testing. For pediatric GHD, CRI, SHOXD, and NS, patient must meet one of the following: 1) height more than 3 SDS below mean for age and gender 2) Height more than 2 SDS below mean with growth velocity more than 1 SDS below mean, or 3) Growth velocity over 1 year 2 SDS below mean. For adult GHD: must meet one of the following: 1) Failed 2 standard GH stimulation tests 2) Panhypopituitarism or 3 or more pituitary hormone deficiencies 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage 4) Low pre-treatment IGF-1 and failed 1 stimulation test prior to starting treatment
Age Restrictions	For SGA: patient is more than 2 years old.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal of pediatric indications: final adult height has not been reached. For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not applicable to patients with panhypopituitarism)

HARVONI

Products Affected

- Harvoni
- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks. 8 weeks per prescriber discretion
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz
- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of non-24-hour sleep-wake disorder and meets the following: patient is totally blind in both eyes and unable to perceive light, for renewals: patient must experience an increase in total nighttime sleep or decreased daytime nap duration. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) and has nighttime sleep disturbance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Renewal: plan year
Other Criteria	N/A

HRM - ANTIDIABETICS

Products Affected

- Glyburide TABS
- Glyburide Micronized
- Glyburide/metformin Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient tried and failed to at least one of the following: glipizide, glipizide/metformin, or has contraindications to all alternatives.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Patient will be monitored for hypoglycemia. Conservative dosing will be used to minimize hypoglycemic events.

HRM - DIGOXIN

Products Affected

- Digitek TABS 0.25MG
- Digox TABS 250MCG
- Digoxin TABS 250MCG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has tried a lower dose (less than or equal to 0.125mg daily) or has contraindications to a lower dose.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	The patient has been counseled on and does not have signs and symptoms of toxicity.

HRM - MUSCLE RELAXANTS

Products Affected

- Chlorzoxazone TABS 500MG
- Cyclobenzaprine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The prescriber must attest that the medication benefits outweigh the potential risks.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally indicated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally indicated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PsO (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR plamoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally indicated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by

	or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	Plan year
Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Hidradenitis suppurativa (HS), Uveitis (Reauth): Documentation of positive clinical response to therapy. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation

	rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer. Ibrance will be used with an aromatase inhibitor as initial endocrine based therapy in postmenopausal women or in men OR with fulvestrant in women with disease progression following endocrine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ICATIBANT

Products Affected

- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of hereditary angioedema. Icatibant will be used for acute attacks of angioedema. Patient has been advised to seek immediate medical attention in addition to treatment with icatibant. Patient has been counseled to use no more than 3 doses in a 24 hour period.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient must not have newly diagnosed chronic phase CML.
Required Medical Information	Patient has a diagnosis of one of the following: accelerated phase or blast phase chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) for whom no other kinase inhibitors are indicated, T315I-positive CML (chronic, accelerated, or blast phase) or T315I-positive Ph+ ALL chronic phase, or CML with resistance or intolerance to at least 2 prior kinase inhibitors.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has an isocitrate dehydrogenase-2 (IDH2) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, D) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, G) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL.
Age Restrictions	18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) and patient has received at least one prior therapy. Diagnosis of chronic lymphocytic leukemia (CLL). Diagnosis of CLL with 17p deletion. Diagnosis of Waldenstrom's macroglobulinemia (WM). Diagnosis of marginal zone lymphoma in patients that have received at least one prior anti-CD20-based therapy such as rituximab. Diagnosis of chronic graft-versus-host disease after failure of one or more lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concomitant monoamine oxidase inhibitor (MAOI) or tetrabenazine.
Required Medical Information	Patient has been clinically diagnosed with moderate to severe tardive dyskinesia including involuntary athetoid or choreiform movements.
Age Restrictions	N/A
Prescriber Restrictions	Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have improvement in symptoms.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma (RCC). Patient has failed one prior systemic therapy, OR patient will use in combination with avelumab or pembrolizumab for first line treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of Myelodysplastic syndrome (MDS). Patient has one of the following French- American-British subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, or chronic myelomonocytic leukemia (CMML).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of intermediate-2 or high risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). Thiamine level was assessed prior to starting treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

INVEGA HAFYERA

Products Affected

- Invega Hafyera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with either once-a-month paliperidone palmitate extended-release injectable suspension (Invega Sustenna) for at least 4 months or an every-three-month paliperidone palmitate extended-release injectable suspension (Invega Trinza) for at least one 3 month cycle. Invega Hafyera will only be given once every 6 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INVEGA TRINZA

Products Affected

- Invega Trinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with Invega Sustenna for at least 4 months. Invega Trinza will only be given once every 3 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IRESSA

Products Affected

- Gefitinib
- Iressa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has metastatic non-small cell lung cancer. The tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Patient is using gefitinib first line.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IVERMECTIN

Products Affected

- Ivermectin TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Using for treatment of COVID-19 infection.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IVIG

Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif
- Gammagard Liquid
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Privigen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of hypersensitivity to immune globulin or any component of the preparation.
Required Medical Information	For a diagnosis of ITP: patient must have a trial of corticosteroids unless platelet count is less than 20,000 cells/mm3 and bleeding has occurred. For a diagnosis of hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia: IgG level is less than 500 mg/dL or patient has a history of infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis). OR Patient has a diagnosis of polycythemia vera and has had an inadequate response to or was intolerant of hydroxyurea. OR Patient has a diagnosis of acute graft-versus-host disease (GVHD) and has failed steroids. OR Patient has a diagnosis of chronic graft-versus-host disease and failed one or more lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	N/A

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, 1. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: A. documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, B. documented skin fibroblast LDL receptor activity less than 20% of normal, OR C. the following criteria are met: a) untreated LDL-C greater than 500 mg/dL or unknown AND b) triglyceride level less than 350 mg/dL AND c) tendon or cutaneous xanthomas at age 10 or younger OR d) both parents with a history of LDL-C greater than 190 mg/dL, AND 2. Patient has tried and had an inadequate response or intolerance to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, 1. Patient meets all initial criteria AND 2. Current LDL-C is improved from the levels immediately prior to initiation of treatment with Juxtapid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Statement from physician or lab results showing patient has cystic fibrosis with a CFTR gene mutation responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. Patient is not homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a rheumatologist
Coverage Duration	Plan year
Other Criteria	RA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline.

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of hormone receptor positive, human epidermal growth factor receptor 2 negative advanced or metastatic breast cancer and will be used with either an aromatase inhibitor as initial endocrine-based therapy OR fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in postmenopausal women or in men. Concomitant use with fulvestrant does not apply to Kisqali Femara Co-Pack requests.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus)
Required Medical Information	Patient has a diagnosis of endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance. Patient has failed surgery or is not a candidate for surgery. Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribing physician must be an endocrinologist
Coverage Duration	Plan year
Other Criteria	N/A

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of neurofibromatosis type 1 and has symptomatic, inoperable plexiform neurofibromas.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KUVAN

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has hyperphenylalaninemia due to Phenylketonuria (PKU).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) and has failed one prior anti-angiogenic therapy and will be used with everolimus or will be used first-line in combination with pembrolizumab, OR patient has a diagnosis of unresectable hepatocellular carcinoma (HCC) OR patient has a diagnosis of advanced endometrial carcinoma and will be used with pembrolizumab and does not have microsatellite instability-high or mismatch repair deficient and has had disease progression following prior systemic therapy. Lenvima will be used in combination with everolimus when used for RCC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LIDODERM

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Diabetic neuropathy, cancer-related neuropathic pain.
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathic pain. The patch will only be applied to intact skin
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of metastatic colorectal cancer: patient has been previously treated with a fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (such as FOLFOX, FOLFIRI, FOLFOXIRI) AND an anti-VEGF biological therapy (such as Avastin), if patient is RAS wild-type, patient has been previously treated with an anti-EGFR therapy. For a diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma: patient has been treated with at least two prior lines of chemotherapy which included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of anaplastic lymphoma kinase (ALK) positive metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with a KRAS G12C mutation and has received at least one prior systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LYNPARZA

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of one of the following: recurrent ovarian cancer (epithelial, fallopian tube, or primary peritoneal) after platinum-based chemotherapy OR Patient has a diagnosis of deleterious or suspected deleterious germline or somatic BRCA-mutated advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to first-line platinum based chemotherapy. OR Patient has a diagnosis of metastatic HER-2 negative breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. OR Patient has a diagnosis of HER2-negative high risk early breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with neoadjuvant or adjuvant chemotherapy. OR Patient has a diagnosis of patient has metastatic pancreatic adenocarcinoma with deleterious or suspected deleterious germline BRCA mutation who had at least 16 weeks of a first-line platinum-based chemotherapy regimen without disease progression. OR Patient has a diagnosis of advanced epithelial ovarian, fallopian tube or primary peritoneal cancer after a complete or partial response to first-line platinum-based chemotherapy, olaparib will be used in combination with bevacizumab, cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation, genomic instability. OR Patient has a diagnosis of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer and disease has progressed following prior treatment with enzalutamide or abiraterone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LYTGOBI

Products Affected

- Lytgobi

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

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient does not have moderate to severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8, 12, or 16 weeks
Other Criteria	N/A

MAYZENT

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients with CYP2C9 3/3, one of the following within the last 6 months: MI, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III or IV HF, Mobitz Type II second degree, third degree AV block, or sick sinus syndrome unless pt has a functioning pacemaker
Required Medical Information	Patient has been tested for CYP2C9 variants. If the patients has CYP2C9 1/3 or 2/3 the patient will be maintained on 1mg daily.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has unresectable or metastatic melanoma with BRAF V600E or V600K mutations and Mekinist will be used as a single agent or with dabrafenib (Tafinlar) and patient has not received prior BRAF-inhibitor therapy (Zelboraf, Tafinlar), OR patient has melanoma with BRAF V600E or V600K mutations and involvement of lymph nodes and Mekinist will be used as adjuvant treatment with dabrafenib after complete resection and has not received prior BRAF-inhibitor therapy, OR patient has a diagnosis of BRAF V600E mutation positive metastatic non-small cell lung cancer and will use in combination with dabrafenib, OR patient has a diagnosis of BRAF V600E mutation-positive locally advanced or metastatic anaplastic thyroid cancer and will be used in combination with dabrafenib. OR patient has a diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation and patient has progressed following prior treatment and has no satisfactory alternative treatment options and will be used in combination with dabrafenib. OR patient has a diagnosis of low grade glioma with BRAF V600E mutation and will be used in combination with dabrafenib
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Binimetinib (Mektovi) will be used in combination with encorafenib (Braftovi). Patient was not previously treated with a BRAF inhibitor or MEK inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MIGLUSTAT

Products Affected

- Miglustat

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of mild to moderate type 1 Gaucher disease. Enzyme replacement therapy is not a therapeutic option due to allergy, hypersensitivity, or poor venous access. Miglustat will be used as monotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of early stage HER2-overexpressed breast cancer and has been on trastuzumab based therapy OR patient has a diagnosis of advanced or metastatic HER2-positive breast cancer and has received 2 or more prior anti-HER2 based regimens and will be used in combination with capecitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NEXAVAR

Products Affected

- Nexavar
- Sorafenib
- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of one of the following: unresectable hepatocellular carcinoma, advanced renal cell carcinoma, or locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of multiple myeloma. Ixazomib will be used in combination with lenalidomide and dexamethasone. Patient has received at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NORTHERA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (due to Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and nondiabetic autonomic neuropathy. Patient must also have tried midodrine.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist.
Coverage Duration	Plan year
Other Criteria	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has non-metastatic, castration-resistant prostate cancer and patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy. Patient has a diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC) and will be using with docetaxel.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of severe asthma with an eosinophilic phenotype and mepolizumab (Nucala) will be used as add-on treatment. For asthma: patient is maintained with high dose inhaled corticosteroid or with medium to high dosed inhaled corticosteroid with a long-acting beta agonist (LABA), and patient has had at least two exacerbations in the past year or at least one exacerbation in the prior year while on daily oral corticosteroid treatment. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA). Patient has a diagnosis of hypereosinophilic syndrome and has been diagnosed at least 6 months prior and does not have an identifiable nonhematologic secondary cause. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps and this will be used as add-on maintenance treatment and patient had an inadequate response to nasal corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	Diagnosis of pseudobulbar affect (PBA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of Parkinson's disease and is experiencing at least one of the following: hallucinations, delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced basal cell carcinoma (BCC). BCC has either recurred following surgery or radiation therapy or patient was not a candidate for surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of idiopathic pulmonary fibrosis, chronic fibrosing interstitial lung diseases with a progressive phenotype, or a diagnosis of systemic sclerosis-associated interstitial lung disease. Liver function tests were performed prior to starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Plan year
Other Criteria	For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of acute myeloid leukemia and achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy and patient is not able to complete intensive curative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has pulmonary arterial hypertension (PAH), World Health Organization Group I disease. PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). Liver function tests were performed prior to starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ORENITRAM

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient has a diagnosis of severe hepatic impairment (Child Pugh Class C).
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed.
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ORSERDU

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	N/A

OSPHENA

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Documentation of positive clinical response to therapy.

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. One of the following: 1) Patient has mild plaque psoriasis, OR 2) Both of the following: a) Patient has moderate to severe plaque psoriasis AND b) TF/C/I to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab), Stelara (ustekinumab), OR 3) for continuation of prior therapy. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plan year
Other Criteria	PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. Oral ulcers associated with Behcet's Disease (reauth): Documentation of

	positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).

OXANDROLONE

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adjunctive therapy for severe burns, AIDS related cachexia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement and patient has been previously treated. Patient has a diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic breast cancer. Patient has HR postive and HER2 negative markers. Patient has PIK3CA mutated disease. Progressed on or after endocrine based regimen. Piqray will be used with fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy 3) Will be used in combination with dexamethasone. For Kaposi sarcoma (KS): patient has AIDS-related KS after failure of highly active antiretroviral therapy or patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of primary hyperlipidemia, homozygous familial hypercholesterolemia, or alirocumab will be used to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in patients with established cardiovascular disease. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. Patient will be started on the 75mg dose. For a diagnosis of clinical atherosclerotic cardiovascular disease or primary hyperlipidemia: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
Required Medical Information	Patient has a diagnosis of chronic immune thrombocytopenic purpura (ITP) and meets both of the following: baseline platelet count less than 50,000/mcL, had an insufficient response to either corticosteroids, immunoglobulins, or splenectomy. Patient has a diagnosis of severe aplastic anemia with a platelet count less than 30,000/mcL. Patient has a diagnosis of thrombocytopenia in a patient with chronic hepatitis C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PROVIGIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced gastrointestinal stromal tumor (GIST). Patient has received 3 or more prior kinase inhibitors, including imatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

QUININE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of uncomplicated Plasmodium falciparum malaria, uncomplicated Plasmodium vivax malaria, or babesiosis. Patient is not prescribed quinine for the treatment or prevention of leg cramps.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has diabetes. Patient has neuropathic ulcers on the lower extremity that extend into the subcutaneous tissue or beyond and have an adequate blood supply (i.e. is not an ischemic ulcer).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	N/A

RELISTOR

Products Affected

- Relistor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient with known or suspected mechanical GI obstruction and at increased risk of recurrent obstruction.
Required Medical Information	Patient has a diagnosis of opioid induced constipation with either chronic non cancer pain or advanced illness or pain caused by cancer who are receiving palliative care, when response to laxative therapy has not been sufficient. Patient has had an inadequate response to Amitiza or Movantik.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH or HoFH), primary hyperlipidemia, or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. For a diagnosis of clinical atherosclerotic cardiovascular disease or primary hyperlipidemia: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin).
Age Restrictions	Patient is 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

RESPIRATORY PDE-5 INHIBITOR

Products Affected

- Alyq
- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has (WHO Group I) PAH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer with RET fusion-positive disease. OR patient has a diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer. OR patient has a diagnosis of advanced or metastatic RET fusion-positive thyroid cancer and is refractory to radioactive iodine (if radioactive iodine is appropriate).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

REVLIMID

Products Affected

- Lenalidomide
- Revlimid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone or as maintenance therapy after autologous hematopoietic stem cell transplant. OR Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5 q cytogenetic abnormality with or without additional cytogenetic abnormalities. OR Diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. AND Patient is not using the medication for the treatment of chronic lymphocytic leukemia. OR Patient has a diagnosis of follicular or marginal zone lymphoma that has been previously treated and will be used with a rituximab product.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

REZLIDHIA

Products Affected

- Rezlidhia

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

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of chronic graft-versus-host disease (chronic GVHD). Patient has had a failure of at least 2 prior lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA) (initial - 15mg): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA - 15mg) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. RA, PsA (initial - 15mg): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Enbrel, Humira). Not used in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). Atopic dermatitis (AD) (initial - 15mg and 30mg): Diagnosis of moderate to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. One of the following: 1) Trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry [tralokinumab-ldrm], Dupixent [dupilumab], etc.), OR 2) Patient has a contraindication, intolerance, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry (tralokinumab-ldrm) and Dupixent (dupilumab). Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	AD (initial): Patient is 12 years of age or older
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (initial): Prescribed by or in consultation with a dermatologist or allergist/immunologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration	Plan year
Other Criteria	Ulcerative colitis (UC) (initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Humira). Not used in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine). RA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. RA, PsA (Reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). AD (reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer with ROS1-positive tumors. OR Patient has solid tumors that meet the following: have a neutrotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, patient has either progressed following treatment or has no satisfactory alternative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic castration resistant prostate cancer with a deleterious BRCA mutation and has been treated with androgen receptor directed therapy and taxane based chemotherapy. OR rucaparib will be used for the maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of new onset acute myeloid leukemia (AML) that is FLT3 mutation positive, aggressive systemic mastocytosis, systemic mastocytosis with associated hematological neoplasm, mast cell leukemia. For patients with AML, midostaurin will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Midostaurin will not be used as a single-agent induction for AML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs) OR Ph+ CML in CP with the T315I mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 75MG/0.83ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR plamoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	Plan year
Other Criteria	Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

SOMATULINE

Products Affected

- Lanreotide Acetate
- Somatuline Depot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of either Acromegaly or gastroenteropancreatic neuroendocrine tumors (GEP-NETs), or carcinoid syndrome. For acromegaly, patient has had an inadequate or partial response to surgery and/or radiotherapy or patient was not a candidate for surgery or radiotherapy. For GEP-NETs, tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gastrointestinal stromal tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	Newly diagnosed adults with Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive CML with resistance or intolerance to prior therapy including imatinib. Adults with diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy. Pediatric patients with a diagnosis of Philadelphia chromosome-positive CML in chronic phase or newly diagnosed Philadelphia chromosome-positive ALL in combination with chemotherapy. For patients with GIST, patient must have progressed on imatinib or sunitinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

STELARA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, or a corticosteroid (eg, prednisone).
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Plan year
Other Criteria	Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab

	values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD (Reauth), UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

STELARA IV

Products Affected

- Stelara INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Plan year
Other Criteria	Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of: A) metastatic colorectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan -based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy or B) gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic AND patient has tried and had an inadequate response, contraindication or intolerance to imatinib and sunitinib or C) hepatocellular carcinoma and has been previously treated with sorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SUTENT

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma or as an adjuvant treatment after nephrectomy. Diagnosis of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib. Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in a patient with unresectable locally advanced or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of type 1 or type 2 diabetes mellitus. Patient is currently receiving optimal mealtime insulin therapy. Patient has had an inadequate treatment response to insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation and will be used in combination with trametinib, OR a diagnosis of unresectable or metastatic melanoma AND will be used as monotherapy in patients with the BRAF V600E mutation OR dabrafenib will be used in combination with trametinib in patients with BRAF V600E or V600K mutations, OR patient has a diagnosis of melanoma with BRAF V600E or V600K mutations with lymph node involvement and will be used in combination with trametinib after complete resection, OR patient has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutations and will be used with trametinib. OR patient has a diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation and patient has progressed following prior treatment and has no satisfactory alternative treatment options and will be used in combination with trametinib. OR patient has a diagnosis of low grade glioma with BRAF V600E mutation and will be used in combination with trametinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of non-small cell lung cancer (NSCLC) and meets the following criteria: patient will use osimertinib as adjuvant therapy after tumor resection and tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, osimertinib will be used first-line in metastatic disease and tumors have EGFR exon 19 deletions or exon 21 L858R mutations, or osimertinib will be used in patients with EGFR T790M mutation-positive metastatic disease and patient has progressed on or after EFGR tyrosine kinase inhibitor therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic breast cancer. Patient has deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated human epidermal growth factor receptor 2 (HER2) negative disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TARGRETIN

Products Affected

- Bexarotene GEL
- Targretin GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For gel: patient has a diagnosis of stage 1A or 1B cutaneous T-cell lymphoma that is refractory or persistent after treatment with other therapies or has not tolerated other therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval or strong CYP3A4 inhibitors.
Required Medical Information	Patient (age 1 or older) has a diagnosis of newly diagnosed Philadelphia chromosome positive CML in chronic phase OR adult patient with a diagnosis of chronic phase or accelerated phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to imatinib OR pediatric patient with a diagnosis of chronic or accelerated phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to prior tyrosine-kinase inhibitor therapy.
Age Restrictions	Age 1 and older for pediatric indications
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of chronic immune thrombocytopenia (ITP). Patient had an insufficient response to a previous treatment.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic or locally advanced epithelioid sarcoma and is not eligible for complete resection. OR Patient has a diagnosis of relapsed or refractory follicular lymphoma with one of the following: tumors are positive for an EZH2 mutation and patient received at least 2 prior systemic therapies, or patient has no satisfactory alternative treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TECFIDERA

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack
  MISC 0

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Patient must have a complete blood count within the past 6 months before initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must demonstrate stabilization or improvement while on dimethyl fumarate.

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tardive dyskinesia, Tourette's syndrome.
Exclusion Criteria	Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease. If treating for tardive dyskinesia, require failure of at least one previous therapy (e.g., amantadine, benzodiazepines, haloperidol, atypical antipsychotics, etc.) or Gilles de la Tourette's syndrome with failure or least one previous therapy (e.g., antipsychotic agents, clonidine). Patients who require doses greater than 50 mg/day will be genotyped for CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have a lack of disease progression or have improvement in symptoms.

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of: A) multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone B) acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum C) Maintenance therapy for prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence. Thalidomide will not be used as monotherapy for erythema nodosum leprosum treatment if the member has moderate to severe neuritis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. OR Patient has a diagnosis of newly-diagnosed AML with a susceptible IDH1 mutation in a patient that is at least 75 years old or who has comorbidities that preclude the use of intensive induction chemotherapy. OR Patient has a diagnosis of previously treated, locally advanced or metastatic cholangiocarcinoma with an IDH1 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TRANSMUCOSAL FENTANYL PRODUCTS

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has active cancer and TIRF will be used for breakthrough cancer pain. Patient has tried and failed or has contraindications to at least 2 of the following short acting narcotics: oxycodone, morphine sulphate, hydromorphone. Long-Acting opioid is being prescribed The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.).
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of cystic fibrosis and at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive based on in vitro data.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TRUSELTIQ

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of advanced unresectable or metastatic breast cancer. Patient has HER2-positive disease and has received one or more prior anti-HER2-based regimen. Tukysa will be used in combination with trastuzumab and capecitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of tenosynovial giant cell tumor (TGCT) and be symptomatic. Patients disease must be associated with severe morbidity or functional limitations and not be amenable to improvement with surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TYKERB

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced or metastatic breast cancer with overexpression of HER2 AND lapatinib will be used with capecitabine AND patient has received prior therapy with an anthracycline, a taxane, and trastuzumab. OR Patient is postmenopausal with a diagnosis of hormone receptor positive metastatic breast cancer with overexpression of HER2 AND lapatinib will be used with letrozole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Will not be used for preventive treatment of migraine. Patient has fewer than 15 headache days per month. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist
Coverage Duration	Plan year
Other Criteria	N/A

UKONIQ

Products Affected

- Ukoniq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of marginal zone lymphoma that is relapsed or refractory and has received at least one prior anti-CD20-based regimen. Patient has a diagnosis of follicular lymphoma that is relapsed or refractory and who has received at least 3 prior lines of treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

UPTRAVI

Products Affected

- Uptravi
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Must not be on a strong CYP3A inhibitor (such as ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, or voriconazole) at Venclexta initiation and during Venclexta ramp-up phase.
Required Medical Information	Patient has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Patient has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) in adults 75 or older or who have comorbidities that preclude the use of intensive induction chemotherapy AND Venclexta will be used in combination with azacitidine, or decitabine, or low-dose cytarabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has advanced or metastatic hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative breast cancer AND patient will use in combination with an aromatase inhibitor as initial treatment in a post menopausal woman or in men OR will be used in combination with fulvestrant in patients that had disease progression following endocrine therapy OR patient has metastatic disease and it will be used as monotherapy for patients that had disease progression following endocrine therapy and prior chemotherapy. Patient has a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence and will be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) and has a Ki-67 score greater than or equal to 20%.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of irritable bowel syndrome with diarrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has solid tumors that have all of the following characteristics: a confirmed neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, metastatic disease or where surgical resection is likely to result in severe morbidity, AND there are no satisfactory alternative treatments or disease has progressed following treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations. Vizimpro will be used as a first-line treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). Patient has a platelet count below 50 x 10 9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma or advanced soft tissue sarcoma. Patients with a diagnosis of soft tissue sarcoma must have received prior chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of von Hippel-Lindau (VHL) disease and requires therapy for associated renal cell carcinoma, central nervous system hemangioblastomas, or pancreatic neuroendocrine tumors (pNET) not requiring immediate surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) and the tumor is ROS1- or ALK-positive. Patient is a pediatric patient or a young adult with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive. Patient has a diagnosis of unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT) that is ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Xeljanz tab/Xeljanz XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally indicated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally indicated doses. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine, olsalazine, sulfasalazine, azathioprine, or corticosteroids (e.g., prednisone). Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Humira). RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Enbrel, Humira). All indications (Initial): Not used in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Plan year

Other Criteria	Xeljanz: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally indicated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Enbrel, Humira). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. All indications (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of carcinoid syndrome diarrhea. Patient will also be on a somatostatin analog (SSA) therapy (e.g., octreotide). Patient has had inadequate control on SSA therapy after a trial of at least 3 months. Patient has at least 4 bowel movements per day.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gastroenterologist.
Coverage Duration	Plan year
Other Criteria	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Diagnosis of multiple myeloma OR 2) diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer), AND documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, pamidronate, Zometa (zoledronic acid).
Age Restrictions	N/A
Prescriber Restrictions	GCTB, HCM: Prescribed by or in consultation with an oncologist
Coverage Duration	MM/BMST, GCTB: 12 mo. HCM: 2 mo.
Other Criteria	Approve for continuation of prior therapy.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of moderate or persistent asthma with base inadequate control on either inhaled corticosteroids and long acting beta agonist or inhaled corticosteroids and long acting muscarinic antagonist, a diagnosis of chronic idiopathic urticaria who remained symptomatic after previous trials of H1 antihistamines, or a diagnosis of nasal polyps and will be used as add-on maintenance in patients with an inadequate response to nasal corticosteroids.
Age Restrictions	Asthma age 6 and older, Chronic idiopathic Urticaria Age 12 and older, nasal polyps age 18 and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has a FMS-like tyrosine kinase 3 (FLT3) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

XPOVIO

Products Affected

- Xpovio
- Xpovio 100 Mg Once Weekly
- Xpovio 40 Mg Once Weekly
- Xpovio 40 Mg Twice Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of relapsed or refractory multiple myeloma (RRMM) and meet one of the following criteria: 1) received at least four prior therapies, disease must be refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody, and therapy must be used in combination with dexamethasone or 2) patient has received at least one prior therapy and it will be used in combination with bortezomib and dexamethasone. OR Patient has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including arising from follicular lymphoma and must have tried at least 2 lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of castration-resistant prostate cancer (CRPC) or metastatic castration-sensitive prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For patients with metastatic, castration-resistant prostate cancer in patients who are not currently taking Xtandi, the patient must have had a trial with abiraterone (Zytiga) unless the patient is unable to try abiraterone.

XYREM

Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Taking alcohol or sedative hypnotic agents while taking sodium oxybate.
Required Medical Information	Patient has a diagnosis of narcolepsy with either cataplexy or excessive daytime sleepiness. For patients with a diagnosis of excessive daytime sleepiness, patient has had a previous trial with or a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has metastatic castration-resistant prostate cancer. Yonsa will be used in combination with methylprednisolone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

YUFLYMA

Products Affected

- Yuflyma 1-pen Kit
- Yuflyma 2-pen Kit
- Yuflyma 2-syringe Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PsO (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by

	or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	Plan Year
Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Hidradenitis suppurativa (HS), Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values

	[platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. OR Patient has a diagnosis of advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with 3 or more prior chemotherapy regimens AND the cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a deleterious or suspected deleterious BRCA mutation or a genomic instability and who have progressed more than 6 months after response to the last platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation OR patient has a diagnosis of Erdheim-Chester Disease (ECD) with BRAF V600E mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient has moderate or severe hepatic impairment (Child-Pugh B or C). Patient is on OATP1B1/3 inhibitors, strong inducers of CYP3A or efavirenz.
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status, NS5A polymorphism status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 wks: G1a Tx-naive or PegIFN/RBV-exp with baseline NS5A or G4 PegIFN/RBV-exp 12 wks for others
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease. Patient has received at least two prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ZTALMY

Products Affected

- Ztalmy

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

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer and has anaplastic lymphoma kinase (ALK)-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 10MG, 2MG/ML, 50MG
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML

- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 10.69GM/L; 300MG/100ML; 570MG/100ML; 70GM/L; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Arformoterol Tartrate
- Astagraf XL
- Azasan
- Azathioprine TABS
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix E 2.75%/dextrose 10% INJ 570MG/100ML; 317MG/100ML; 33MG/100ML; 10GM/100ML; 283MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML

- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 8/10
- Clinimix N14g30e
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Doxorubicin Hcl INJ 2MG/ML, 50MG
- Doxorubicin Hydrochloride INJ 10MG
- Dronabinol
- Duopa
- Emend SUSR
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Formoterol Fumarate NEBU
- Freamine Hbc 6.9%

- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nephramine
- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG

- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Procalamine
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Synthamin 17
- Tacrolimus CAPS
- Tobramycin NEBU

- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Varubi TBPK
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Voriconazole INJ

Details

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

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