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## Medicare Plus Blue<sup>SM</sup> PPO Essential, Vitality, Signature and Assure Plus Comprehensive Formulary Prior Authorization / Step Therapy Program 2024 Plan Year Updated 5/1/2024

BCBSM – Medicare Plus Blue PPO Essential, Vitality, Signature and Assure monitors the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization** (PA) for these drugs means that either clinical and/or administrative criteria must be met before coverage is provided. Drugs subject to **step therapy** (ST) may require previous treatment with one or more formulary drugs prior to coverage. Drugs that must meet clinical/administrative criteria are identified in the formulary list with (PA) or (ST). Medications that require PA or ST are listed below. Drugs with PA criteria are listed first followed by drugs with ST criteria. Please refer to the Formulary to verify if your drugs are covered. Your physician can contact our pharmacy help desk to request prior authorization or step therapy for these drugs.

The clinical criteria for authorization are based on current medical information and the recommendations of the Blues' Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts.

Please call the customer service number on the back of your Blue Cross member ID card if you have questions about your drug coverage or a drug claim.

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Last Updated: April 2024

Formulary ID: 24341, Version: 14

## ACITRETIN

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### Products Affected

- Acitretin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ACTIMMUNE

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### Products Affected

- Actimmune

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ADEMPAS

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### Products Affected

- Adempas

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ADLARITY

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### Products Affected

- Adlarity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF GENERIC ORAL DONEPEZIL.

## AFINITOR

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## AFINITOR DISPERZ

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### Products Affected

- Everolimus TBSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# AIMOVIG

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## Products Affected

- Aimovig

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE).



## AKEEGA

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### Products Affected

- Akeega

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ALECENSA

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### Products Affected

- Alecensa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ALOSETRON

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### Products Affected

- Alosetron Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ALPHA-1-PROTEINASE INHIBITORS

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### Products Affected

- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PATIENTS MUST HAVE A DIAGNOSIS OF NECROTIZING PANNICULITIS OR ALPHA-1 ANTITRYPSIN DEFICIENCY WITH AN FEV1 LESS THAN OR EQUAL TO 80% PREDICTED.
<b>Age Restrictions</b>	PATIENTS 18 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	DOCUMENTATION OF A CONGENITAL DEFICIENCY OF ALPHA-1 ANTITRYPSIN, DEMONSTRATED BY A HOMOZYGOUS PHENOTYPE OF AAT, AND MUST HAVE SYMPTOMATIC EMPHYSEMA.

## ALUNBRIG

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### Products Affected

- Alunbrig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## APOKYN

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### Products Affected

- Apomorphine Hydrochloride INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF CARBIDOPA/LEVODOPA ER (EXTENDED RELEASE).

# APTIOM

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## Products Affected

- Aptiom

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# ARCALYST

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## Products Affected

- Arcalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF RECURRENT PERICARDITIS REQUIRES A TRIAL OF A NONSTEROIDAL ANTI-INFLAMMATORY DRUG IN COMBINATION WITH COLCHICINE.



## AUBAGIO

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### Products Affected

- Teriflunomide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## AUGTYRO

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### Products Affected

- Augtyro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## AURYXIA

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### Products Affected

- Auryxia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## AVONEX

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### Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## AYVAKIT

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### Products Affected

- Ayvakit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## BALVERSA

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### Products Affected

- Balversa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BANZEL

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### Products Affected

- Rufinamide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BENLYSTA

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### Products Affected

- Benlysta INJ 200MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## BESREMI

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### Products Affected

- Besremi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BETASERON

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### Products Affected

- Betaseron

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BOSULIF

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### Products Affected

- Bosulif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BRAFTOVI

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### Products Affected

- Braftovi CAPS 75MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BRIVIACT

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### Products Affected

- Briviact SOLN
- Briviact TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

## BRONCHITOL

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### Products Affected

- Bronchitol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION THAT THE MEMBER HAS PASSED THE BRONCHITOL TOLERANCE TEST.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## BRUKINSA

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### Products Affected

- Brukinsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## CABLIVI

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### Products Affected

- Cablivi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# CABOMETYX

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## Products Affected

- Cabometyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# CALCIPOTRIENE

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## Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	REQUIRES TRIAL OF AT LEAST ONE GENERIC TOPICAL STEROID.

## CALQUENCE

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### Products Affected

- Calquence

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## CAMZYOS

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### Products Affected

- Camzyos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## CAPRELSA

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### Products Affected

- Caprelsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# CAYSTON

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## Products Affected

- Cayston

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## CERDELGA

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### Products Affected

- Cerdelga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# CHOLBAM

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## Products Affected

- Cholbam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



## CLOMIPHENE

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### Products Affected

- Clomid
- Clomiphene Citrate TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## CLOZAPINE ODT

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### Products Affected

- Clozapine Odt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# COMETRIQ

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## Products Affected

- Cometriq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# COPAXONE

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## Products Affected

- Glatiramer Acetate
- Glatopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## COPIKTRA

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### Products Affected

- Copiktra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## COSENTYX

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### **Products Affected**

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

Prior Authorization Criteria

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (AXSPA) REQUIRES A DIAGNOSIS OF NON-RADIOGRAPHIC AXSPA AND OBJECTIVE SIGNS OF INFLAMMATION. COVERAGE FOR NON-RADIOGRAPHIC AXSPA ALSO REQUIRES THE TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ENTHESITIS-RELATED ARTHRITIS (ERA) REQUIRES A DIAGNOSIS OF ACTIVE ERA AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>

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# COTELLIC

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## Products Affected

- Cotellic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# CYSTARAN

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## Products Affected

- Cystaran

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## DALIRESP

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### Products Affected

- Roflumilast

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	ONE YEAR
<b>Other Criteria</b>	A. Coverage is provided for the treatment of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis in patients with a history of exacerbations. B. Patient is receiving: inhaled long-acting beta-2 agonist [for example, formoterol, salmeterol] AND at least one additional therapy from the following categories: inhaled long-acting anticholinergic agent [for example, tiotropium] OR inhaled corticosteroid [for example, fluticasone] OR If patient experienced intolerance or has contraindications to use of these medications.

## DANYELZA

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### Products Affected

- Danyelza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## DAURISMO

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### Products Affected

- Daurismo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# DAYBUE

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## Products Affected

- Daybue

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR ATYPICAL OR VARIANT RETT SYNDROME.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## DEFERASIROX

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### Products Affected

- Deferasirox TBSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# DIACOMIT

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## Products Affected

- Diacomit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

## DIHYDROERGOTAMINE NASAL SPRAY

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### Products Affected

- Dihydroergotamine Mesylate SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF TWO TRIPTANS ON THE FORMULARY: ONE ORAL TRIPTAN AND ONE NON-ORAL TRIPTAN (SUCH AS NASAL SPRAY OR INJECTION).



## DOJOLVI

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### Products Affected

- Dojolvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## DOPTELET

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### Products Affected

- Doptelet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## DRIZALMA SPRINKLE

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### Products Affected

- Drizalma Sprinkle

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## DULERA

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### Products Affected

- Dulera

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR ASTHMA REQUIRES A DIAGNOSIS OF ASTHMA AND TRIAL OF ONE OF THE FOLLOWING: 1. BREO ELLIPTA OR 2. ADVAIR HFA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

## **DUPIXENT**

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### **Products Affected**

- Dupixent

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	EOE: PATIENT MUST WEIGH AT LEAST 15 KILOGRAMS
<b>Age Restrictions</b>	AD: AT LEAST 6 MONTHS OF AGE. EA, CDA: AT LEAST 6 YEARS OF AGE. EOE: AT LEAST 1 YEAR OF AGE. PN, CRSWNP: AT LEAST 18 YEARS OF AGE.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR ATOPIC DERMATITIS (AD) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID (SUCH AS FLUOCINONIDE), TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, METHOTREXATE, AZATHIOPRINE, MYCOPHENOLATE MOFETIL. COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR CORTICOSTEROID DEPENDENT ASTHMA (CDA) REQUIRES DIAGNOSIS OF MODERATE TO SEVERE ASTHMA, CURRENTLY DEPENDENT ON ORAL CORTICOSTEROIDS. COVERAGE FOR EA AND CDA ALSO REQUIRES CONCURRENT STANDARD OF CARE REGIMEN AND FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST

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Prior Authorization Criteria

	<p>(LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP, CONCURRENT STANDARD OF CARE REGIMEN, AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). COVERAGE FOR EOSINOPHILIC ESOPHAGITIS (EOE) REQUIRES DIAGNOSIS OF SYMPTOMATIC EOE AND TRIAL OF EITHER 1) A PROTON PUMP INHIBITOR (E.G., PANTOPRAZOLE, OMEPRAZOLE) OR 2) TOPICAL (ESOPHAGEAL) CORTICOSTEROIDS (E.G., INHALED BUDESONIDE, INHALED FLUTICASONE). COVERAGE FOR PRURIGO NODULARIS (PN) REQUIRES DIAGNOSIS OF PN AND TRIAL OF A TOPICAL STEROID. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>
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# EMGALITY

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## Products Affected

- Emgality

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE).



## EMSAM

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### Products Affected

- Emsam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **ENBREL**

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### **Products Affected**

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR JUVENILE PSORIATIC ARTHRITIS (JPSA) REQUIRES A DIAGNOSIS OF ACTIVE JPSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>

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## ENDARI

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### Products Affected

- Endari

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PATIENT HAS EXPERIENCED 2 OR MORE SICKLE CELL-RELATED CRISES IN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	REQUIRES THE TRIAL OF OR INTOLERANCE TO HYDROXYUREA.

## ENHERTU

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### Products Affected

- Enhertu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## EPCLUSA

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### Products Affected

- Epclusa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

# EPIDIOLEX

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## Products Affected

- Epidiolex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF LENNOX-GASTAUT SYNDROME REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES. COVERAGE FOR A DIAGNOSIS OF DRAVET SYNDROME REQUIRES A TRIAL OF 2 OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, OR TOPIRAMATE. COVERAGE FOR TREATMENT OF SEIZURES ASSOCIATED WITH TUBEROUS SCLEROSIS COMPLEX REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES.

# EPRONTIA

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## Products Affected

- Eprontia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR THE PREVENTATIVE TREATMENT OF MIGRAINE REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ALTERNATIVES FOR MIGRAINE PREVENTION, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES. COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER/EPILEPSY REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES



## ERIVEDGE

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### Products Affected

- Erivedge

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST OR DERMATOLOGIST
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ERLEADA

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### Products Affected

- Erleada

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ERYTHROPOIESIS STIMULATING AGENTS

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### Products Affected

- Aranesp Albumin Free INJ  
100MCG/0.5ML, 100MCG/ML,  
10MCG/0.4ML, 150MCG/0.3ML,  
200MCG/0.4ML, 200MCG/ML,  
25MCG/0.42ML, 25MCG/ML,  
300MCG/0.6ML, 40MCG/0.4ML,  
40MCG/ML, 500MCG/ML,  
60MCG/0.3ML, 60MCG/ML
- Epogen INJ 10000UNIT/ML,  
20000UNIT/ML, 2000UNIT/ML,  
3000UNIT/ML, 4000UNIT/ML
- Procrit

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	THREE MONTHS
<b>Other Criteria</b>	ERYTHROPOIESIS STIMULATING AGENTS ARE SUBJECT TO PART B VS PART D REVIEW.

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## ESBRIET

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### Products Affected

- Pirfenidone CAPS
- Pirfenidone TABS 267MG, 801MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## EXKIVITY

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### Products Affected

- Exkivity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# FARYDAK

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## Products Affected

- Farydak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **FASENRA**

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### **Products Affected**

- Fasenra
- Fasenra Pen

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR EA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR EA ALSO REQUIRES CONCURRENT STANDARD OF CARE REGIMEN. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

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# FILSPARI

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## Products Affected

- Filspari

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	REQUIRES BOTH OF THE FOLLOWING: 1) A TRIAL OF A MAXIMALLY TOLERATED DOSE OF AN ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR AN ANGIOTENSIN RECEPTOR BLOCKER(ARB) AND 2) A TRIAL OF ONE OF THE FOLLOWING: METHYLPREDNISOLONE, PREDNISOLONE OR PREDNISONE

# FILSUEZ

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## Products Affected

- Filsuvez

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE FOR DYSTROPHIC EPIDERMOLYSIS BULLOSA (DEB) AND JUNCTIONAL EPIDERMOLYSIS BULLOSA (JEB) WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS: 1. CURRENT EVIDENCE OR A HISTORY OF MALIGNANCY (E.G., BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA), OR ACTIVE INFECTION IN THE AREA UNDERGOING TREATMENT, OR 2. PRIOR STEM CELL TRANSPLANT OR GENE THERAPY FOR THE TREATMENT OF INHERITED EPIDERMOLYSIS BULLOSA
<b>Required Medical Information</b>	COVERAGE FOR DYSTROPHIC EPIDERMOLYSIS BULLOSA (DEB) AND JUNCTIONAL EPIDERMOLYSIS BULLOSA (JEB) REQUIRES THAT THE PATIENT HAS OPEN WOUNDS REQUIRING TREATMENT
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# FINTEPLA

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## Products Affected

- Fintepla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF TWO OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, TOPIRAMATE.

# FIRAZYR

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## Products Affected

- Icatibant Acetate
- Sajazir

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## FIRDAPSE

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### Products Affected

- Firdapse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# FORTEO

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## Products Affected

- Forteo INJ 600MCG/2.4ML
- Teriparatide INJ 620MCG/2.48ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 YEARS
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF BOTH 1) PROLIA AND 2) EITHER AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH ALL OF THE FOLLOWING: PROLIA, AN ORAL BISPHOSPHONATE, AND AN INTRAVENOUS BISPHOSPHONATE.

## FOTIVDA

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### Products Affected

- Fotivda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## FRUZAQLA

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### Products Affected

- Fruzaqla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## FYCOMPA

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### Products Affected

- Fycompa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# GATTEX

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## Products Affected

- Gattex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION OF DEPENDENCE ON PARENTERAL SUPPORT FOR 12 MONTHS OR GREATER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# GAVRETO

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## Products Affected

- Gavreto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# GILENYA

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## Products Affected

- Fingolimod Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# GILOTRIF

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## Products Affected

- Gilotrif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## GLP-1 AGONISTS

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### Products Affected

- Bydureon Bcise
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	EXCLUDED IF USED FOR THE TREATMENT OF WEIGHT LOSS ONLY
<b>Required Medical Information</b>	ONE OF THE FOLLOWING: A) FOR PATIENTS REQUIRING ONGOING TREATMENT FOR TYPE 2 DIABETES MELLITUS (T2DM), SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM, OR B) SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM AS EVIDENCED BY ONE OF THE FOLLOWING LABORATORY VALUES: I) A1C GREATER THAN OR EQUAL TO 6.5%, II) FASTING PLASMA GLUCOSE (FPG) GREATER THAN OR EQUAL TO 126 MG/DL, OR III) 2-HOUR PLASMA GLUCOSE (PG) GREATER THAN OR EQUAL TO 200 MG/DL DURING OGTT (ORAL GLUCOSE TOLERANCE TEST).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

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## GROWTH HORMONE

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### Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PEDIATRIC PATIENTS REQUIRES FOR ALL INDICATIONS MUST BE PRESCRIBED BY AN ENDOCRINOLOGIST OR NEPHROLOGIST.
<b>Coverage Duration</b>	PEDIATRICS EQUALS ONE YEAR. ADULTS EQUALS LIFETIME
<b>Other Criteria</b>	N/A

## HAEGARDA

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### Products Affected

- Haegarda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	6 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# HARVONI

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## Products Affected

- Harvoni

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

# HEMADY

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## Products Affected

- Hemady

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# HETLIOZ

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## Products Affected

- Tasimelteon

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# HUMIRA

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## Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR CROHN’S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE</p>

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Prior Authorization Criteria

	<p>(RHEUMATREX/TREXALL). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRINE (6-MP), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), DIPENTUM (OLSALAZINE), AZULFIDINE (SULFASALAZINE)], IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE). COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. COVERAGE FOR UVEITIS REQUIRES A DIAGNOSIS OF NON-INFECTIOUS UVEITIS CLASSIFIED AS ONE OF THE FOLLOWING: INTERMEDIATE, POSTERIOR, PANUVEITIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>
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# HYFTOR

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## Products Affected

- Hyftor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## IBRANCE

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### Products Affected

- Ibrance

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## ICLUSIG

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### Products Affected

- Iclusig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A

## IDHIFA

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### Products Affected

- Idhifa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## IMATINIB MESYLATE

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### Products Affected

- Imatinib Mesylate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## IMBRUVICA

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### Products Affected

- Imbruvica

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## IMVEXXY

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### Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# INCRELEX

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## Products Affected

- Increlex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# INLYTA

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## Products Affected

- Inlyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# INQOVI

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## Products Affected

- Inqovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A



## INREBIC

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### Products Affected

- Inrebic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## IRESSA

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### Products Affected

- Gefitinib

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ISOTRETINOIN

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### Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Myorisan
- Zenatane

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF EITHER AN ORAL ANTIBIOTIC OR A BENZOYL PEROXIDE CONTAINING TOPICAL THERAPY.

## IVERMECTIN

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### Products Affected

- Ivermectin TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## IWILFIN

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### Products Affected

- Iwilfin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## JADENU

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### Products Affected

- Deferasirox TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# JAKAFI

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## Products Affected

- Jakafi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST, HEMATOLOGIST, OR TRANSPLANT SPECIALIST.
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## JAYPIRCA

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### Products Affected

- Jaypirca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# JOENJA

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## Products Affected

- Joenja

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	FOR TREATMENT OF ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS): CANNOT BE USED IN COMBINATION WITH AN IMMUNOSUPPRESSIVE MEDICATION.
<b>Required Medical Information</b>	COVERAGE FOR ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS) REQUIRES ALL OF THE FOLLOWING: 1. A DIAGNOSIS OF APDS WITH AN ASSOCIATED PI3K $\delta$ MUTATION, 2. DOCUMENTED VARIANT IN EITHER PIK3CD OR PIK3R1, AND 3. DOCUMENTED SYMPTOMS ASSOCIATED WITH APDS SUCH AS NODAL AND/OR EXTRANODAL LYMPHOPROLIFERATION, HISTORY OF REPEATED OTO-SINO-PULMONARY INFECTIONS AND/OR ORGAN DYSFUNCTION (E.G. LUNG, LIVER).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## KALYDECO

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### Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## KERENDIA

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### Products Affected

- Kerendia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# KETOCONAZOLE

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## Products Affected

- Ketoconazole TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# KEVZARA

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## Products Affected

- Kevzara

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, HUMIRA, RINVOQ, XELJANZ/XR, ORENCIA. COVERAGE FOR POLYMYALGIA RHEUMATICA (PMR) REQUIRES BOTH OF THE FOLLOWING: 1) HISTORY OF TREATMENT WITH CORTICOSTEROIDS AT A DOSE OF GREATER THAN 10 MG PER DAY PREDNISONE EQUIVALENT FOR AT LEAST 8 WEEKS AND 2) INADEQUATE RESPONSE OR INTOLERANCE TO CORTICOSTEROIDS AS DEMONSTRATED BY A DISEASE FLARE DURING CORTICOSTEROID TAPER AT A DOSE OF GREATER THAN 7.5 MG PER DAY PREDNISONE EQUIVALENT. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Last Updated: April 2024

Formulary ID: 24341, Version: 14

# KINERET

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## Products Affected

- Kineret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, HUMIRA, RINVOQ, XELJANZ/XR, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# KISQALI

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## KORLYM

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### Products Affected

- Korlym
- Mifepristone TABS 300MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# KOSELUGO

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## Products Affected

- Koselugo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# KRAZATI

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## Products Affected

- Krazati

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# LENVIMA

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## 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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## LEUPROLIDE

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### Products Affected

- Leuprolide Acetate INJ  
1MG/0.2ML, 22.5MG
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month) INJ  
7.5MG
- Lupron Depot-ped (3-month) INJ  
11.25MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# LIBTAYO

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## Products Affected

- Libtayo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## LIDOCAINE TOPICALS

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### Products Affected

- Lidocaine PTCH 5%
- Lidocaine/prilocaine CREA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 YEARS
<b>Other Criteria</b>	N/A

# LIVTENCITY

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## Products Affected

- Livtencity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## LONSURF

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### Products Affected

- Lonsurf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# LORBRENA

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## Products Affected

- Lorbrena

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# LUMAKRAS

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## Products Affected

- Lumakras

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# LUMOXITI

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## Products Affected

- Lumoxiti

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## LYNPARZA

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### Products Affected

- Lynparza TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## LYTGOBI

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### Products Affected

- Lytgobi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# MARGENZA

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## Products Affected

- Margenza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# MEKINIST

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## Products Affected

- Mekinist TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## MEKINIST LIQUID FORMULATION

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### Products Affected

- Mekinist SOLR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.



# MEKTOVI

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## Products Affected

- Mektovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# MEMANTINE

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## Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN  
2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	PRIOR AUTHORIZATION APPLIES ONLY TO PATIENTS LESS THAN 30 YEARS OF AGE.

# MEPROBAMATE

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## Products Affected

- Meprobamate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## MIGLUSTAT

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### Products Affected

- Miglustat
- Yargesa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# MONJUVI

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## Products Affected

- Monjuvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# MOTPOLY XR

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## Products Affected

- Motpoly Xr

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR SEIZURES REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANT ALTERNATIVES, ONE OF WHICH MUST BE GENERIC LACOSAMIDE.

# MOVANTIK

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## Products Affected

- Movantik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 1 YEAR
<b>Other Criteria</b>	REQUIRES A DIAGNOSIS OF OPIOID INDUCED CHRONIC CONSTIPATION IN MEMBERS WITH CHRONIC, NON-CANCER PAIN. A MEMBER MUST BE STABLE ON OPIOID THERAPY FOR A MINIMUM OF 2 WEEKS.

# MYALEPT

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## Products Affected

- Myalept

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBING PHYSICIAN IS AN ENDOCRINOLOGIST
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## NARCOLEPSY AGENTS

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### Products Affected

- Armodafinil
- Modafinil TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## NARCOTIC ANALGESICS

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### Products Affected

- Fentanyl Citrate Oral Transmucosal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## NATPARA

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### Products Affected

- Natpara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# NAYZILAM

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## Products Affected

- Nayzilam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## NERLYNX

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### Products Affected

- Nerlynx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## NEXAVAR

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### Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# NEXLETOL

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## Products Affected

- Nexletol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	DIAGNOSIS OF ESTABLISHED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE OR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF ONE HIGH INTENSITY STATIN AT MAXIMUM TOLERATED DOSE, UNLESS THE PATIENT HAS EXPERIENCED INTOLERANCE TO OR HAS CONTRAINDICATIONS TO A STATIN MEDICATION. EXAMPLES OF STATIN INTOLERANCE INCLUDE SKELETAL MUSCLE RELATED SYMPTOMS OR RHABDOMYOLYSIS.

# NEXLIZET

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## Products Affected

- Nexlizet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	DIAGNOSIS OF ESTABLISHED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE OR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF ONE HIGH INTENSITY STATIN AT MAXIMUM TOLERATED DOSE, UNLESS THE PATIENT HAS EXPERIENCED INTOLERANCE TO OR HAS CONTRAINDICATIONS TO A STATIN MEDICATION. EXAMPLES OF STATIN INTOLERANCE INCLUDE SKELETAL MUSCLE RELATED SYMPTOMS OR RHABDOMYOLYSIS.



# NINLARO

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## Products Affected

- Ninlaro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## NIVESTYM

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### Products Affected

- Nivestym

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## NORTHERA

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### Products Affected

- Droxidopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF MIDODRINE AND FLUDROCORTISONE.

## NUBEQA

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### Products Affected

- Nubeqa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## NUCALA

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### **Products Affected**

- Nucala

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	EGPA: COVERAGE REQUIRES TWO OF THE FOLLOWING CRITERIA THAT ARE TYPICAL OF EGPA: 1) HISTOPATHOLOGICAL EVIDENCE OF EOSINOPHILIC VASCULITIS, PERIVASCULAR EOSINOPHILIC INFILTRATION, OR EOSINOPHIL-RICH GRANULOMATOUS INFLAMMATION, 2) NEUROPATHY, 3) PULMONARY INFILTRATES, 4) ALLERGIC RHINITIS AND NASAL POLYPS, 5) CARDIOMYOPATHY, 6) GLOMERULONEPHRITIS, 7) ALVEOLAR HEMORRHAGE, 8) PALPABLE PURPURA, 9) ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA) POSITIVITY.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR EA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR EA ALSO REQUIRES CONCURRENT STANDARD OF CARE REGIMEN. COVERAGE FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA AND

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Prior Authorization Criteria

	<p>HISTORY OR PRESENCE OF ASTHMA. COVERAGE FOR HYPEREOSINOPHILIC SYNDROME (HES) REQUIRES DIAGNOSIS OF HES AND EOSINOPHIL COUNT OF AT LEAST 1000 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR HES ALSO REQUIRES BOTH OF THE FOLLOWING: 1) TWO HES FLARES WITHIN THE PAST 12 MONTHS (WORSENING SYMPTOMS OR EOSINOPHIL COUNTS REQUIRING ESCALATION IN THERAPY) AND STABILITY ON HES THERAPY (SUCH AS ORAL CORTICOSTEROIDS, IMMUNOSUPPRESSIVE, OR CYTOTOXIC THERAPY). COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP, CONCURRENT STANDARD OF CARE REGIMEN, AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.</p>
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# NUEDEXTA

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**Products Affected**

- Nuedexta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE REQUIRES THE PRESENCE OF AN UNDERLYING NEUROLOGICAL CONDITION CAUSING SYMPTOMS OF PBA (EX. MULTIPLE SCLEROSIS, AMYOTROPHIC LATERAL SCLEROSIS, PARKINSON’S DISEASE, STROKE, TRAUMATIC BRAIN INJURY)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



## NUPLAZID

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### Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# NURTEC

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## Products Affected

- Nurtec

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE PREVENTION OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO DIFFERENT CHRONIC MIGRAINE PREVENTION DRUGS FROM TWO DISTINCT CLASSES, SUCH AS ANTICONVULSANTS (TOPIRAMATE, VALPROATE), BETA BLOCKERS (PROPRANOLOL, METOPROLOL), AND ANTIDEPRESSANTS (NORTRIPTYLINE, VENLAFAXINE). FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN.

## OCTREOTIDE ACETATE

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ODOMZO

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### Products Affected

- Odomzo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## OFEV

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### Products Affected

- Ofev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## OGSIVEO

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### Products Affected

- Ogsiveo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## OJJAARA

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### Products Affected

- Ojjaara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# ONUREG

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## Products Affected

- Onureg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## OPFOLDA

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### Products Affected

- Opfolda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES CONFIRMATION OF DIAGNOSIS BY SERUM ASSAY SHOWING A DECREASE OF ACID ALPHA-GLUCOSIDASE ACTIVITY FOLLOWED BY GENETIC TESTING SHOWING A MUTATION IN THE GAA GENE.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE PRESENCE OF SYMPTOMATIC MANIFESTATIONS OF THE DISEASE INCLUDING, BUT NOT LIMITED TO: PROGRESSIVE MUSCLE WEAKNESS, RESPIRATORY FAILURE, FREQUENT UPPER AIRWAY INFECTIONS, ORTHOPNEA, SLEEP APNEA, AND/OR MORNING HEADACHES (MUST NOT BE PRESENT WITH ONLY CARDIAC HYPERTROPHY).

## ORENCIA

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### **Products Affected**

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

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS)
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING ABATACEPT IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS).

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## ORENITRAM ER

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE IS PROVIDED FOR THE DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION. REQUIRES TRIAL AND FAILURE OR CONTRAINDICATION TO INHALED TREPROSTINIL AND SILDENAFIL.

## ORFADIN

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### Products Affected

- Nitisinone
- Orfadin SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# ORGOVYX

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## Products Affected

- Orgovyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO FIRMAGON. FOR MA-PD PLANS, THE TRIAL OF FIRMAGON MAY BE PART B BEFORE PART D STEP THERAPY.

## ORKAMBI

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### Products Affected

- Orkambi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ORSERDU

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### Products Affected

- Orserdu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# OTEZLA

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## Products Affected

- Otezla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF PLAQUE PSORIASIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# OXBRYTA

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## Products Affected

- Oxbryta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO HYDROXYUREA.

## PADCEV

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### Products Affected

- Padcev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## PANRETIN

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### Products Affected

- Panretin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## PEMAZYRE

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### Products Affected

- Pemazyre

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# PHENOBARBITAL

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## Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG

PA Criteria	Criteria Details
Indications	All Medically-accepted 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	1 YEAR
Other Criteria	N/A

## PIQRAY

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## POLIVY

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### Products Affected

- Polivy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



## POMALYST

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### Products Affected

- Pomalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## PRETOMANID

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### Products Affected

- Pretomanid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# PROLIA

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## Products Affected

- Prolia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR HYPOCALCEMIA.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 YEARS
<b>Other Criteria</b>	PROLIA IS SUBJECT TO PART B VERSUS PART D REVIEW. COVERAGE REQUIRES TRIAL OF AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH BOTH ORAL AND INTRAVENOUS BISPHOSPHONATES.

## PROMACTA

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### Products Affected

- Promacta TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR A DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA (ITP) REQUIRES BASELINE PLATELET COUNT OF LESS THAN 30,000 MCL AND SYMPTOMS OF ACTIVE BLEEDING. COVERAGE FOR A DIAGNOSIS OF THROMBOCYTOPENIA WITH CHRONIC HEPATITIS C REQUIRES BASELINE PLATELET COUNT LESS THAN 75,000 MCL. COVERAGE FOR A DIAGNOSIS OF SEVERE APLASTIC ANEMIA REQUIRES BASELINE PLATELET COUNT OF LESS THAN 30,000 MCL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR ITP REQUIRES TRIAL OF CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY

## PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

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### Products Affected

- Alyq
- Ambrisentan
- Bosentan
- Opsumit
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG
- Tracleer TBSO

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR SILDENAFIL AND TADALAFIL IN SITUATIONS WHERE PATIENTS ARE RECEIVING NITRATE THERAPY.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## PYRUKYND

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### Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# QINLOCK

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## Products Affected

- Qinlock

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# QUININE

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## Products Affected

- Quinine Sulfate CAPS 324MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## RADICAVA ORS

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### Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS) REQUIRES THE FOLLOWING: 1. START OF TREATMENT IS WITHIN 2 YEARS OF DIAGNOSIS WITH ALS OR AFTER 2 YEARS OF DIAGNOSIS, WITH A PERCENT PREDICTED VITAL CAPACITY VALUE OF GREATER THAN OR EQUAL TO 80% 2. SUBMISSION OF A BASELINE METRICS FROM THE ALSFRS-R (REVISED ALS FUNCTIONAL RATING SCALE) 3. CURRENTLY RECEIVING TREATMENT WITH RILUZOLE.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ALS: MUST BE PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	RENEWAL REQUIRES SUBMISSION OF PATIENT ASSESSMENTS USING THE ALSFRS-R OR OTHER CLINICAL DOCUMENTATION TO DETERMINE IF RADICAVA IS SLOWING THE PROGRESSION OF ALS.

# RAVICTI

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## Products Affected

- Ravicti

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# REBIF

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## Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF AVONEX OR BETASERON

## RECORLEV

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### Products Affected

- Recorlev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES A TRIAL OF KETOCONAZOLE, MITOTANE, OR CABERGOLINE.

# RELISTOR

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## Products Affected

- Relistor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	PATIENTS WITH KNOWN OR SUSPECTED MECHANICAL GASTROINTESTINAL OBSTRUCTION
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	PATIENTS 18 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	THREE MONTHS
<b>Other Criteria</b>	N/A

## REPATHA

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### Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 YEARS
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO ONE HIGH INTENSITY STATIN.

## RETEVMO

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### Products Affected

- Retevmo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## REVCovi

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### Products Affected

- Revcovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## REVLIMID

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### Products Affected

- Lenalidomide
- Revlimid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MUST BE PRESCRIBED BY AN ONCOLOGIST OR HEMATOLOGIST
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# REXULTI

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## Products Affected

- Rexulti

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF SCHIZOPHRENIA REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE.

## REZLIDHIA

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### Products Affected

- Rezlidhia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## REZUROCK

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### Products Affected

- Rezero

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **RINVOQ**

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### **Products Affected**

- Rinvoq

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE (AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN), CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE). COVERAGE FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (AXSPA) REQUIRES A DIAGNOSIS OF NON-RADIOGRAPHIC AXSPA AND OBJECTIVE SIGNS OF INFLAMMATION. COVERAGE FOR NON-</p>

Last Updated: April 2024

Formulary ID: 24341, Version: 14

Prior Authorization Criteria

	<p>RADIOGRAPHIC AXSPA ALSO REQUIRES THE TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR CROHN’S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX/TREXALL). COVERAGE FOR RA, PSA, UC, AS, CD, AND AXSPA ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITORS (E.G., ENBREL, HUMIRA) OR DOCUMENTATION DEMONSTRATING THAT A TRIAL MAY BE INAPPROPRIATE. COVERAGE FOR ATOPIC DERMATITIS (AD) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID (SUCH AS FLUOCINONIDE), TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, METHOTREXATE, AZATHIOPRINE, MYCOPHENOLATE MOFETIL. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES</p>
<p><b>Other Criteria</b></p>	<p>DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING UPADACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).</p>

# RIVFLOZA

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## Products Affected

- Rivfloza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS, 1) PATIENT HAS A HISTORY OF KIDNEY OR LIVER TRANSPLANT, 2) COMBINATION USE WITH OXLUMO.
<b>Required Medical Information</b>	DIAGNOSIS OF PRIMARY HYPEROXALURIA TYPE 1 (PH1) CONFIRMED BY GENETIC TESTING OF THE AGXT MUTATION.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## ROZLYTREK

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### Products Affected

- Rozlytrek

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## RUBRACA

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### Products Affected

- Rubraca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## RYBREVANT

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### Products Affected

- Rybrevant

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## RYDAPT

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### Products Affected

- Rydapt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## RYLAZE

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### Products Affected

- Rylaze

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## SAMSCA

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### Products Affected

- Tolvaptan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE REQUIRES DOCUMENTATION THAT THE PATIENT DOES NOT HAVE UNDERLYING LIVER DISEASE
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 MONTH
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF AT LEAST TWO OF THE FOLLOWING TREATMENTS: FUROSEMIDE, DEMECLOCYCLINE, OR FLUID RESTRICTION.

## SAPROPTERIN HYDROCHLORIDE

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### Products Affected

- Sapropterin Dihydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	INITIAL - 2 MONTHS AUTH WILL BE EXTENDED FOR 1 YEAR IF DOCUMENTED RESPONSE AFTER INITIAL THERAPY
<b>Other Criteria</b>	RENEWAL CRITERIA: PATIENT MUST SHOW IMPROVEMENT AFTER INITIAL THERAPY OF 2 MONTHS.

## SARCLISA

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### Products Affected

- Sarclisa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# SAVELLA

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## Products Affected

- Savella
- Savella Titration Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF FIBROMYALGIA REQUIRES A TRIAL OF GABAPENTIN.

## SCSEMBLIX

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### Products Affected

- Scemblix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## SIGNIFOR

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### Products Affected

- Signifor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# SIRTURO

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## Products Affected

- Sirturo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	MUST BE USED IN COMBINATION WITH AT LEAST 3 OTHER AGENTS.

## SKYCLARYS

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### Products Affected

- Skyclarys

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# SKYRIZI

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**Products Affected**

- Skyrizi INJ 150MG/ML
- Skyrizi Pen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSORIATIC ARTHRITIS. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

## SKYRIZI 360 MG

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### Products Affected

- Skyrizi INJ 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX/TREXALL). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

# SOHONOS

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## Products Affected

- Sohonos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR A DIAGNOSIS OF FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) REQUIRES GENETIC TESTING CONFIRMATION SHOWING AN ACVR1 MUTATION.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## SOMATULINE DEPOT

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### Products Affected

- Somatuline Depot

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## SOMAVERT

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### Products Affected

- Somavert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# SOVALDI

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## Products Affected

- Sovaldi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

## SPRITAM

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### Products Affected

- Spritam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

## SPRYCEL

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### Products Affected

- Sprycel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB.

## STELARA

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### Products Affected

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

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE OF 90MG/ML STRENGTH FOR A DIAGNOSIS OF PSA OR PLAQUE PSORIASIS REQUIRES PATIENT WEIGHT GREATER THAN 100KG (220LBS).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (PURINETHOL), AZATHIOPRINE (IMURAN), A CORTICOSTEROID (EG, PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE (RHEUMATREX, TREXALL). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE (AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN), CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Last Updated: April 2024

Formulary ID: 24341, Version: 14

## STIVARGA

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### Products Affected

- Stivarga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# SUTENT

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## Products Affected

- Sunitinib Malate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MUST BE PRESCRIBED BY AN ONCOLOGIST.
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## SYMLIN

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### Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	SYMLIN IS COVERED FOR PATIENTS THAT HAVE FAILED INTENSIVE TREATMENT WITH INSULIN MONOTHERAPY AND FOR CONCURRENT USE WITH AN INSULIN PRODUCT.

## SYMPAZAN

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### Products Affected

- Clobazam
- Sympazan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## SYNRIBO

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### Products Affected

- Synribo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## TABLOID

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### Products Affected

- Tabloid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by an oncologist or hematologist
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# TABRECTA

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## Products Affected

- Tabrecta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

# TAFINLAR

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## Products Affected

- Tafinlar CAPS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## TAFINLAR LIQUID FORMULATION

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### Products Affected

- Tafinlar TBSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW CAPSULE FORMULATION.



# TAGRISSE

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## Products Affected

- Tagrisso

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# TALZENNA

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## Products Affected

- Talzenna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TARCEVA

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## Products Affected

- Erlotinib Hydrochloride TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MUST BE PRESCRIBED BY AN ONCOLOGIST.
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TARGRETIN

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## Products Affected

- Bexarotene

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MUST BE PRESCRIBED BY A ONCOLOGIST OR DERMATOLOGIST
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TASIGNA

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## Products Affected

- Tassigna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB.

# TAZAROTENE

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**Products Affected**

- Tazarotene CREA
- Tazarotene GEL
- Tazorac CREA 0.05%

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TAZVERIK

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## Products Affected

- Tazverik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TECFIDERA

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## Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack  
CDPK 0

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A



# TEGSEDI

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## Products Affected

- Tegsedi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TEPMETKO

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## Products Affected

- Tepmetko

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TESTOSTERONE

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## Products Affected

- Testosterone GEL  
20.25MG/1.25GM, 25MG/2.5GM,  
40.5MG/2.5GM
- Testosterone Pump GEL 1.62%

PA Criteria	Criteria Details
Indications	All Medically-accepted 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	1 YEAR
Other Criteria	N/A

# TETRABENAZINE

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## Products Affected

- Tetrabenazine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS, 1) HEPATIC FUNCTION IMPAIRMENT 2) ACTIVELY SUICIDAL OR WHO HAVE UNTREATED OR INADEQUATELY TREATED DEPRESSION, 3) TAKING MONOAMINE OXIDASE INHIBITORS OR RESERPINE.
<b>Required Medical Information</b>	DOCUMENTATION OF THE CYP2D6 GENOTYPE OF THE PATIENT WILL BE REQUIRED FOR DOSES ABOVE 50MG PER DAY.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# THALOMID

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## Products Affected

- Thalomid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TIBSOVO

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## Products Affected

- Tibsovo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TIVDAK

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## Products Affected

- Tivdak

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## TOPICAL NON STEROIDAL ANTI-INFLAMMATORIES

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### Products Affected

- Diclofenac Epolamine
- Flector

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	ONE MONTH
<b>Other Criteria</b>	N/A



## TOPICAL TRETINOIN

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### Products Affected

- Avita CREA
- Tretinoin CREA
- Tretinoin GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TRELSTAR

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## Products Affected

- Trelstar Mixject

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## TRIENTINE HCL

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### Products Affected

- Trientine Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TRIKAFTA

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## Products Affected

- Trikafta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# TRODELVY

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## Products Affected

- Trodelvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

# TRUQAP

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## Products Affected

- Truqap

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TRUSELTIQ

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## Products Affected

- Truseltiq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TUKYSA

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## Products Affected

- Tukysa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A



# TURALIO

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## Products Affected

- Turalio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TYKERB

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## Products Affected

- Lapatinib Ditosylate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# TYMLOS

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## Products Affected

- Tymlos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 YEARS
<b>Other Criteria</b>	COVERAGE REQUIRES TRIAL OF BOTH 1) PROLIA AND 2) EITHER AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH ALL OF THE FOLLOWING: PROLIA, AN ORAL BISPHOSPHONATE, AND AN INTRAVENOUS BISPHOSPHONATE.

# TYVASO DPI

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## Products Affected

- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION (PAH) WHO GROUP 1 REQUIRES A TRIAL OF BOTH OF THE FOLLOWING: 1) GENERIC SILDENAFIL OR TADALAFIL AND 2) GENERIC AMBRISENTAN OR BOSENTAN

# UBRELVY

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## Products Affected

- Ubrelvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN.

## VALCHLOR

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### Products Affected

- Valchlor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VALTOCO

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## Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## VANFLYTA

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### Products Affected

- Vanflyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## VENCLEXTA

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### Products Affected

- Venclexta
- Venclexta Starting Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VEOZAH

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## Products Affected

- Veozah

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR MODERATE-TO-SEVERE VASOMOTOR SYMPTOMS (VMS) DUE TO MENOPAUSE REQUIRES A TRIAL, FAILURE, CONTRAINDICATION OR INTOLERANCE TO ONE PREFERRED OR GENERIC MEDICATION FOR THE TREATMENT OF VMS.

# VERQUVO

## Products Affected

- Verquvo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE REQUIRES A DIAGNOSIS OF CHRONIC HEART FAILURE NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV AND LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF LESS THAN 45%. COVERAGE ALSO REQUIRES ONE OF THE FOLLOWING: 1. PREVIOUS HOSPITALIZATION FOR HEART FAILURE WITHIN PRIOR 6 MONTHS OR 2. OUTPATIENT INTRAVENOUS (IV) DIURETIC TREATMENT FOR HEART FAILURE WITHIN PRIOR 3 MONTHS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	MUST BE TAKEN IN COMBINATION WITH AT LEAST TWO OF THE FOLLOWING UNLESS CONTRAINDICATED OR NOT TOLERATED: 1. METOPROLOL SUCCINATE, CARVEDILOL, OR BISOPROLOL 2. AN ACE-INHIBITOR (ACE, SUCH AS LISINOPRIL), ANGIOTENSIN RECEPTOR BLOCKER (ARB, SUCH AS LOSARTAN), OR ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR (ARNI, SUCH AS SACUBITRIL/VALSARTAN) 3. A SODIUM GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR APPROVED FOR HEART FAILURE 4. A MINERALOCORTICOID RECEPTOR ANTAGONIST

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# VERSACLOZ

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## Products Affected

- Versacloz

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VERZENIO

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## Products Affected

- Verzenio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## VIGABATRIN

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### Products Affected

- Vigabatrin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## VIJOICE

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### Products Affected

- Vioice

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## VITRAKVI

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### Products Affected

- Vitrakvi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# VIVJOA

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## Products Affected

- Vivjoa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	REQUIRES THE TRIAL OF OR INTOLERANCE TO GENERIC FLUCONAZOLE ALONE.

## VIZIMPRO

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### Products Affected

- Vizimpro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VONJO

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## Products Affected

- Vonjo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VORICONAZOLE

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## Products Affected

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# VOSEVI

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## Products Affected

- Vosevi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

# VOTRIENT

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## Products Affected

- Pazopanib Hydrochloride
- Votrient

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MUST BE PRESCRIBED BY AN ONCOLOGIST.
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## VYNDAMAX

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### Products Affected

- Vyndamax

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## VYNDAQEL

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### Products Affected

- Vyndaqel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## WELIREG

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### Products Affected

- Welireg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# XALKORI

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## Products Affected

- Xalkori

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **Xcopri**

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### **Products Affected**

- Xcopri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

# XDEMVY

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## Products Affected

- Xdemvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR DEMODEX BLEPHARITIS REQUIRES CONFIRMATION OF DIAGNOSIS OF DEMODEX BLEPHARITIS VIA THE PRESENCE OF COLLARETTES UPON EXAMINATION WITH A SLIT LAMP.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **XELJANZ**

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### **Products Affected**

- Xeljanz
- Xeljanz Xr

Prior Authorization Criteria

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	<p>COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC AND A TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES: 6-MERCAPTOPYRIMIDINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE (AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN),</p>

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Prior Authorization Criteria

	<p>CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE). FOR ALL INDICATIONS: COVERAGE ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITOR (E.G., ENBREL, HUMIRA) OR DOCUMENTATION DEMONSTRATING THAT A TRIAL MAY BE INAPPROPRIATE. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING TOFACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).</p>
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## XERMELO

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### Products Affected

- Xermelo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A



## XGEVA

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### Products Affected

- Xgeva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# XIFAXAN

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## Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR A DIAGNOSIS OF HEPATIC ENCEPHALOPATHY REQUIRES A TRIAL OF LACTULOSE. COVERAGE FOR IRRITABLE BOWEL SYNDROME WITH DIARRHEA REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING: LOPERAMIDE, DICYCLOMINE, OR DIPHENOXYLATE/ATROPINE. COVERAGE FOR RECURRENT CLOSTRIDIUM DIFFICILE DIARRHEA (C. DIFF) REQUIRES TRIAL OF VANCOMYCIN. COVERAGE FOR SMALL INTESTINAL BACTERIAL OVER-GROWTH (SIBO) IS NOT PROVIDED.

## **XOLAIR**

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### **Products Affected**

- Xolair

Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
<b>Required Medical Information</b>	ALLERGIC ASTHMA: IMMUNOGLOBULIN E (IGE) LEVEL GREATER THAN 30 AND LESS THAN 700 UNITS PER MILLILITER (IU/ML) FOR 12 YEARS AND OLDER, GREATER THAN 30 AND LESS THAN 1300 IU/ML FOR 6 YEARS THROUGH 12 YEARS  CRSWNP: IMMUNOGLOBULIN E (IGE) LEVEL BETWEEN 30 AND 1500 IU/ML AT INITIATION OF TREATMENT
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR UNCONTROLLED MODERATE TO SEVERE ALLERGIC ASTHMA REQUIRES DIAGNOSIS OF THIS CONDITION WITH A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN. COVERAGE FOR THIS CONDITION ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR CHRONIC IDIOPATHIC URTICARIA (CIU) REQUIRES A DIAGNOSIS OF CIU AND A TRIAL OF AT LEAST ONE SECOND GENERATION ANTIHISTAMINE AND ONE OF THE FOLLOWING: ANOTHER SECOND-GENERATION ANTIHISTAMINE, H2 ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, FIRST GENERATION

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Formulary ID: 24341, Version: 14

Prior Authorization Criteria

	ANTI-HISTAMINE, HYDROXYZINE, OR DOXEPIN. COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP, CONCURRENT STANDARD OF CARE REGIMEN, AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
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## XOSPATA

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### Products Affected

- Xospata

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## XPHOZAH

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### Products Affected

- Xphozah

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# XPOVIO

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



# XTANDI

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## Products Affected

- Xtandi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE FOR METASTATIC CASTRATION RESISTANT PROSTATE CANCER (CRPC) AND METASTATIC CASTRATION SENSITIVE PROSTATE CANCER (CSPC) REQUIRES TRIAL OF ABIRATERONE.

# XYREM

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**Products Affected**

- Sodium Oxybate
- Xyrem

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	COVERAGE IS NOT PROVIDED FOR PATIENTS TAKING SEDATIVE HYPNOTICS OR IN PATIENTS WITH SUCCINIC SEMIALDEHYDE DEHYDROGENASE DEFICIENCY.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

# YONSA

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## Products Affected

- Yonsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	One Year
<b>Other Criteria</b>	N/A

## ZARXIO

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### Products Affected

- Zarxio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## **ZEJULA**

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### **Products Affected**

- Zejula

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ZELBORAF

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### Products Affected

- Zelboraf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ZEPZELCA

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### Products Affected

- Zepzelca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ZILBRYSQ

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### Products Affected

- Zilbrysq



Prior Authorization Criteria

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	PATIENTS MUST NOT HAVE A HISTORY OF THE FOLLOWING: 1. THYMECTOMY WITHIN 12 MONTHS, 2. CURRENT THYMOMA, OR 3. OTHER NEOPLASMS OF THE THYMUS. CANNOT BE USED IN COMBINATION WITH OTHER BIOLOGIC THERAPIES FOR MYASTHENIA GRAVIS OR IMMUNOGLOBULIN THERAPY.
<b>Required Medical Information</b>	COVERAGE REQUIRES DOCUMENTATION OF ANTI-ACETYLCHOLINE RECEPTOR (AChR) ANTIBODY POSITIVE MYASTHENIA GRAVIS (MG) IDENTIFIED BY: 1. LAB RECORD OR CHART NOTES IDENTIFYING THE PATIENT IS POSITIVE FOR ANTI-AChR ANTIBODIES AND 2. ONE OF THE FOLLOWING CONFIRMATORY TESTS: A. POSITIVE EDROPHONIUM TEST, B. HISTORY OF CLINICAL RESPONSE TO ORAL CHOLINESTERASE INHIBITORS (EX: PYRIDOSTIGMINE) OR C. ELECTROPHYSIOLOGICAL EVIDENCE OF ABNORMAL NEUROMUSCULAR TRANSMISSION BY REPETITIVE NERVE STIMULATION (RNS) OR SINGLE-FIBER ELECTROMYOGRAPHY (SFEMG).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	COVERAGE REQUIRES PREVIOUS TREATMENT COURSES OF AT LEAST 12 WEEKS WITH ONE OF THE FOLLOWING STANDARDS OF CARE HAVE BEEN INEFFECTIVE: METHOTREXATE, AZATHIOPRINE, CYCLOPHOSPHAMIDE, CYCLOSPORINE, MYCOPHENOLATE MOFETIL, OR TACROLIMUS, UNLESS ALL ARE CONTRAINDICATED OR NOT TOLERATED. COVERAGE ALSO REQUIRES PATIENT IS CURRENTLY RECEIVING AND WILL CONTINUE TO RECEIVE A STABLE STANDARD OF CARE REGIMEN.

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## ZOLINZA

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### Products Affected

- Zolozina

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ZONISADE

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### Products Affected

- Zonisade

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC ZONISAMIDE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES

## ZTALMY

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### Products Affected

- Ztalmy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ZURZUVAE

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### Products Affected

- Zurzuvae

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	COVERAGE FOR POSTPARTUM DEPRESSION (PPD) REQUIRES BOTH OF THE FOLLOWING: 1. A DIAGNOSIS OF PPD WITH AN ONSET OF DEPRESSIVE SYMPTOMS IN THE THIRD TRIMESTER OR WITHIN 4 WEEKS POSTPARTUM AND 2. MEMBER IS CURRENTLY LESS THAN OR EQUAL TO 12 MONTHS POSTPARTUM.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	60 DAYS
<b>Other Criteria</b>	N/A

## ZYDELIG

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### Products Affected

- Zydelig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A

## ZYKADIA

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### Products Affected

- Zykadia TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 Year
<b>Other Criteria</b>	N/A

## ZYTIGA

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### Products Affected

- Abiraterone Acetate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 YEAR
<b>Other Criteria</b>	N/A



## **PART B VERSUS PART D**

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## Prior Authorization Criteria

### Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Arformoterol Tartrate
- Astagraf XL
- Azathioprine TABS
- Budesonide SUSP
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Emend SUSR
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Flebogamma Dif INJ 10GM/100ML, 20GM/200ML, 5GM/50ML
- Gammagard Liquid
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepelisav-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

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## Prior Authorization Criteria

- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU  
0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- 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
- Privigen
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU

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## Prior Authorization Criteria

- 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
- Tyvaso
- Tyvaso Refill
- Tyvaso Starter
- Ventavis

## Prior Authorization Criteria

### **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.

## **ABILIFY ASIMTUFII**

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### **Products Affected**

- Abilify Asimtufii

### **Details**

<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPIRAZOLE. COVERAGE DURATION IS LIFETIME.
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## ABILIFY MAINTENA

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### Products Affected

- Abilify Maintena

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.
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## ANTIDEPRESSANTS

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### Products Affected

- Auvelity
- Desvenlafaxine Er TB24 100MG, 50MG
- Fetzima
- Fetzima Titration Pack
- Trintellix
- Viibryd Starter Pack

### Details

<b>Criteria</b>	REQUIRES TRIAL OF AT LEAST 2 FORMULARY GENERIC ANTIDEPRESSANTS. COVERAGE DURATION IS LIFETIME.
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## ANTIPSYCHOTIC AGENTS

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### Products Affected

- Caplyta
- Fanapt
- Fanapt Titration Pack
- Lybalvi
- Secuado
- Vraylar
- Zyprexa Relprevv

### Details

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<b>Criteria</b>	REQUIRES TRIAL OF AT LEAST ONE GENERIC ANTIPSYCHOTIC AGENT. COVERAGE DURATION IS LIFETIME.
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## APIDRA

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### Products Affected

- Apidra
- Apidra Solostar

### Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO NOVOLOG 70/30 OR NOVOLOG.COVERAGE DURATION IS LIFETIME.
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## ARISTADA

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### Products Affected

- Aristada

### Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME
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## ARISTADA INITIO

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### Products Affected

- Aristada Initio

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.
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## BYSTOLIC

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### Products Affected

- Nebivolol Hydrochloride

### Details

<b>Criteria</b>	REQUIRES THAT MEMBER HAS TRIED OR IS INTOLERANT TO AT LEAST 2 OF THE FORMULARY CARDIOSELECTIVE BETA BLOCKERS. COVERAGE DURATION IS LIFETIME.
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# HUMALOG

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## Products Affected

- Humalog
- Humalog Junior Kwikpen
- Humalog Kwikpen
- Humalog MIX 50/50
- Humalog MIX 50/50 Kwikpen
- Humalog MIX 75/25
- Humalog MIX 75/25 Kwikpen
- Insulin Lispro
- Insulin Lispro Junior Kwikpen
- Insulin Lispro Kwikpen
- Insulin Lispro Protamine/insulin Lispro Kwikpen

## Details

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<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO NOVOLOG 70/30 OR NOVOLOG. COVERAGE DURATION IS LIFETIME.
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# HUMULIN

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## Products Affected

- Humulin 70/30 INJ 30UNIT/ML;  
70UNIT/ML
- Humulin 70/30 Kwikpen
- Humulin N
- Humulin N Kwikpen
- Humulin R

## Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO NOVOLIN 70/30, NOVOLIN N OR NOVOLIN R. COVERAGE DURATION IS LIFETIME.
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## INTRANASAL STEROIDS

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### Products Affected

- Omnaris

### Details

<b>Criteria</b>	CLAIMS FOR BRAND NASAL STEROID SPRAY PRODUCTS WILL PROCESS IF A CLAIM FOR AT LEAST 30 DAYS OF A GENERIC NASAL STEROID SPRAY HAS PROCESSED IN THE PAST 120 DAYS. COVERAGE DURATION IS ONE YEAR.
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# INVEGA HAFYERA

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## Products Affected

- Invega Hafyera

## Details

<b>Criteria</b>	REQUIRES TRIAL OF A ONCE-A MONTH PALIPERIDONE PALMITATE EXTENDED-RELEASE INJECTABLE SUSPENSION FOR AT LEAST 4 MONTHS OR AN EVERY-THREE-MONTH PALIPERIDONE PALMITATE EXTENDED -RELEASE INJECTABLE SUSPENSION FOR AT LEAST ONE THREE MONTH CYCLE. COVERAGE DURATION IS LIFETIME.
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## INVEGA SUSTENNA

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### Products Affected

- Invega Sustenna

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL PALIPERIONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# INVEGA TRINZA

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## Products Affected

- Invega Trinza

## Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL PALIPERIDONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## PANCREAZE

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### Products Affected

- Pancreaze CPEP 149900UNIT;  
37000UNIT; 97300UNIT,  
15200UNIT; 2600UNIT; 8800UNIT,  
24600UNIT; 4200UNIT;  
14200UNIT, 61500UNIT;  
10500UNIT; 35500UNIT,  
83900UNIT; 21000UNIT;  
54700UNIT, 98400UNIT;  
16800UNIT; 56800UNIT

### Details

<b>Criteria</b>	REQUIRES TRIAL OR INTOLERANCE TO CREON. COVERAGE DURATION IS LIFETIME.
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## PERSERIS

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### Products Affected

- Perseris

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME
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## RISPERDAL CONSTA

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### Products Affected

- Risperdal Consta
- Risperidone Er

### Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## **RYKINDO**

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### **Products Affected**

- Rykindo

### **Details**

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<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# ULORIC

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## Products Affected

- Febuxostat

## Details

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<b>Criteria</b>	REQUIRES TRIAL OR CONTRAINDICATION OF ALLOPURINOL. COVERAGE DURATION IS LIFETIME.
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# UZEDY

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## Products Affected

- Uzedy

## Details

<b>Criteria</b>	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## VUMERITY

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### Products Affected

- Vumerity

Step Therapy Criteria

**Details**

<b>Criteria</b>	COVERAGE REQUIRES TRIAL OF DIMETHYL FUMARATE. COVERAGE DURATION IS ONE YEAR.
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