Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medicare Plus Blue℠ Group PPO and Prescription Blue℠ Group PDP
Group Comprehensive Formulary and Group Enhanced Comprehensive Formulary
Prior Authorization / Step Therapy Program
2022 Plan Year
Updated 12/1/2021

BCBSM –Medicare Plus Blue Group PPO and Prescription Blue Group PDP monitor 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). If drugs listed below have a **(g)** noted, the **PA** or **ST** criteria may also apply to the generic version of the drug. In some cases, the brand name drug is listed for reference and the generic drug is covered. 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.

MEDICATION/ DRUG CLASS	CRITERIA
Abilify Maintena® (aripiprazole)	Coverage requires trial of oral aripiprazole. **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Actemra® Subcutaneous (tocilizumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Adempas® (riociguat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Afinitor® (g) (everolimus)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Afinitor Disperz® (everolimus)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Alecensa® (alectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Alpha-1 Proteinase Inhibitors **Prolastin-C®** **Zemaira®**	Coverage requires documentation of a diagnosis of necrotizing panniculitis or alpha-1 antitrypsin deficiency with an FEV1 less than or equal to 65% predicted. Coverage also requires documentation of a congenital deficiency of alpha-1 antitrypsin, demonstrated by a homozygous phenotype of AAT, and must have symptomatic emphysema. *All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Alunbrig™ (brigatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ampyra® (g) (dalfampridine)	Initial requests require documentation of a 25-foot timed walk test. Renewal of therapy requires documentation that the member has shown an improvement in walking distance of a 25-foot timed walk test compared to pretreatment. *All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing physician is a neurologist. **Exclusion criteria:** Patients with a history of seizure or moderate to severe renal impairment defined by a CrCl of 50ml/min or less. **Coverage duration:** Initial approval is for 3 months. Reauthorization is for 1 year.
Anabolic Steroids **Oxandrin® (g)** (oxandrolone)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided if anabolic steroids are used to enhance athletic performance or for anti-aging purposes. **Coverage duration:** 1 year.
Anticonvulsants **Oxtellar XR®** (oxcarbazepine)	Coverage requires trial or intolerance to at least 2 generic anticonvulsants. **Coverage duration**: Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Antidepressants **Trintellix®** (vortioxetine) **Desvenlafaxine ER** **Fetzima™** (levomilnacipran) **Fetzima™ Titration Pack** (levominacipran) **Viibryd®** (vilazodone)	Coverage requires the trial of at least 2 formulary generic antidepressants. **Coverage duration:** Lifetime.
Antipsychotic Agents **Caplyta®** (lumateperone) **Latuda®** (lurasidone) **Lybalvi™** (olanzapine/samidorphan) **Saphris® (**asenapine) **Secuado®** (asenapine) **Vraylar™** (cariprazine) **Zyprexa® Relprevv™** (olanzapine)	Coverage requires that the member has had a trial of at least one generic antipsychotic agent. **Coverage duration:** Lifetime.
Apidra® (insulin glulisine)	Coverage requires that the member has had a trial or intolerance to Novolog® or Novolog® 70/30. **Coverage duration:** Lifetime.
Arcalyst® (rilonacept)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Arikayce® (amikacin liposome inhalation suspension)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Aristada™ (aripiprazole lauroxil)	Coverage requires trial or intolerance to Abilify Maintena or oral aripiprazole. **Coverage duration:** Lifetime.
Aristada Initio™ (aripiprazole lauroxil)	Coverage requires trial of oral aripiprazole. **Coverage duration:** Lifetime.
Aubagio® (teriflunomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Auryxia® (ferric citrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Avonex® **(**interferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Ayvakit™ (avapritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Balversa™ (erdafitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Berinert® (C1 inhibitor, human)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Betaseron® (interferon beta-1b)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Blenrep (belantamab mafodotin-blmf)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Bosulif® (bosutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Braftovi™ (encorafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Briviact® (brivaracetam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Bronchitol® (mannitol)	Coverage requires documentation that the member has passed the Bronchitol® tolerance test. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Brukinsa™ (zanubrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Bystolic® (nebivolol)	Requires the trial of at least 2 of the formulary cardioselective beta blockers. **Coverage duration:** Lifetime.
Cablivi® (caplacizumab-yhdp)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cabometyx™ (cabozantinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Calquence® (acalabrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cayston® (aztreonam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cholbam® (cholic acid)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Cialis® (g) 2.5mg, 5mg (tadalafil)	**Cialis 2.5mg or 5mg**: Coverage of 31 tablets per 31 days requires the diagnosis of benign prostatic hyperplasia (BPH). **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Cimzia® (certolizumab pegol)	Coverage will be provided for the diagnosis of rheumatoid arthritis when there has been a trial of two of the following preferred agents: tocilizumab (Actemra®) SC, etanercept (Enbrel®), adalimumab (Humira®), or tofacitinib (Xeljanz®/Xeljanz® XR). Coverage will be provided for the diagnosis of ankylosing spondylitis when there has been a trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), or adalimumab (Humira®). Coverage will be provided for the diagnosis of psoriatic arthritis when there has been a trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®), apremilast (Otezla®), ustekinumab (Stelara®), or tofacitinib (Xeljanz®/Xeljanz® XR). Coverage will be provided for the diagnosis of Crohn's disease when there has been a trial of adalimumab (Humira®) or ustekinumab (Stelara®). Coverage will be provided for the diagnosis of moderate to severe plaque psoriasis when there has been a trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®), ustekinumab (Stelara®), or apremilast (Otezla®). *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Clomiphene	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year. ***For Group Enhanced Formulary Only*** Coverage is also provided for the treatment of female infertility.

MEDICATION/ DRUG CLASS	CRITERIA
Cometriq® (cabozantinib s-malate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Copaxone® (glatiramer acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Copiktra™ (duvelisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cosentyx® (secukinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cotellic™ (cobimetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Danyelza® (naxitamab-gqgk)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Daurismo™ (glasdegib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Diacomit® (stiripentol)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Dojolvi™ (triheptanoin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Doptelet® (avatrombopag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Dovonex® (g) (calcipotriene)	Coverage requires the trial of at least one generic topical steroid. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Enbrel® (etanercept)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Enhertu® (fam-trastuzumab deruxtecan-nxki)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Enspryng™ (satralizumab-mwge)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Epclusa® (sofosbuvir/velpatasvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Epidiolex® (cannabidiol)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 Year.
Erivedge® (vismodegib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing Physician is an oncologist or dermatologist. **Coverage duration:** 1 Year.
Erleada™ (apalutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage Duration:** 1 Year.
Erythropoiesis Stimulating Agents **Aranesp®(**darbepoetin), **Epogen®** (epoetin alfa), **Procrit®** (epoetin alfa)	Erythropoiesis stimulating agents are subject to Part B versus Part D review. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 3 months.

MEDICATION/ DRUG CLASS	CRITERIA
Esbriet® (pirfenidone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 Year.
Evrysdi™ (risdiplam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Exkivity™ (mobocertinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Extavia® (Interferon beta-1B)	Coverage requires trial of at least one of the following: Interferon Beta-1B (Betaseron®), Interferon Beta-1A (Avonex®), Peginterferon Beta-1A (Plegridy®) or Interferon Beta-1A (Rebif®) *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Farydak® (panobinostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Fintepla® (fenfluramine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Firazyr® (g) (icatibant acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age and older. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Firdapse® (amifampridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Forteo® (teriparatide)	Coverage requires documentation of bone mineral density that is 2.5 standard deviations or more below the mean (T-score at or below -2.5). Coverage also requires that the patient has tried and failed at least one bisphosphonate except when: 1. There is a contraindication to an oral and intravenous bisphosphonate (such as a stricture or aclasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration). 2. There is documented intolerance to a bisphosphonate. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Fotivda® (tivozanib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Galafold™ (migalastat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gamifant® (emapalumab-lzsg)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Gattex® (teduglutide)	Coverage requires documentation of dependence on parenteral support for 12 months or greater. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gavreto™ (pralsetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gilenya® (fingolimod hydrochloride)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gilotrif® (afatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gleevec® (g) (imatinib mesylate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Growth Hormone (somatropin), **Humatrope®, Norditropin®, Nutropin®, Omnitrope®, Serostim®, Zomacton™**	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** For pediatric patients, all indications must be prescribed by a pediatric endocrinologist or pediatric nephrologist. **Coverage duration:** Pediatrics: 1 year. Adults: Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Haegarda® (C1 Inhibitor, Human)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 6 years of age and older. **Coverage duration:** 1 year.
Harvoni™ (ledipasvir/sofosbuvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Hemady™ (dexamethasone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Hetlioz™ (tasimelteon)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Humalog® Insulin (Insulin Lispro) **Humalog® Mix Insulin** (Insulin Lispro Protamine-Insulin Lispro)	Coverage requires trial or intolerance to Novolog® or Novolog® 70/30. **Coverage duration:** Lifetime.
Humira® (adalimumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Humulin® Insulin (Humulin® R, Humulin® N, Humulin® 70/30)	Coverage requires a trial of or intolerance to Novolin® 70/30, Novolin® N or Novolin® R. **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Ibrance® (palbociclib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Iclusig® (ponatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Idhifa® (enasidenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ilaris® (canakinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Imbruvica™ (ibrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Increlex® (mecasermin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Inlyta® (axitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Inqovi® (decitabine and cedazuridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Inrebic® (fedratinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Invega Hafyera™ (paliperidone palmitate)	Coverage requires the 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:** Lifetime.
Invega Sustenna® (paliperidone palmitate)	Coverage requires the trial of oral paliperidone or oral risperidone. **Coverage duration:** Lifetime.
Invega Trinza™ (paliperidone palmitate)	Coverage requires the trial of oral paliperidone or oral risperidone. **Coverage duration:** Lifetime.
Jakafi® (ruxolitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restriction:** Prescribing physician is an oncologist, hematologist, or transplant specialist. **Coverage duration:** 1 year.
Jemperli (dostarlimab-gxly)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Jynarque™ (tolvaptan)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Kalydeco™ (ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Kineret® (anakinra)	Coverage will be provided for the diagnosis of rheumatoid arthritis when there has been a trial of two of the following preferred agents: tocilizumab (Actemra®) SC, etanercept (Enbrel®), adalimumab (Humira®), tofacitinib (Xeljanz®/Xeljanz® XR). *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Kisqali® (ribociclib) **Kisqali® Femara® Co-Pack** (ribociclib & letrozole)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Korlym™ (mifepristone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Koselugo™ (selumetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lenvima™ (lenvatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Libtayo® (cemiplimab-rwlc)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lidoderm® Patch (g) (lidocaine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lonsurf® (trifluridine and tipiracil)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Lorbrena® (lorlatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lotronex® (g) (alosetron)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lumakras™ (sotorasib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lumoxiti™ (moxetumomab pasudotox-tdfk)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lynparza™ (olaparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Megace® (g) (megestrol)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Mekinist™ (trametinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Mektovi® (binimetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Monjuvi™ (tafasitamab-cxix)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Movantik™ (Naloxegol Oxalate)	Coverage is provided for diagnosis of opioid induced chronic constipation with chronic, non-cancer pain. Member must be stable on opioid therapy for a minimum of 2 weeks. *All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Coverage duration:** Initial=3 months. Renewal=1 year.
Myalept® (metreleptin)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing physician must be an endocrinologist. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Narcolepsy Agents **Nuvigil® (g)** (armodafinil) **Provigil® (g)** (modafanil)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Narcotic analgesics (fentanyl citrate) **Actiq® (g)** **Fentora®** **Lazanda®** **Subsys™**	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Natpara® (parathyroid hormone, recombinant)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nerlynx™ (neratinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nexavar® (sorafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ninlaro® (ixazomib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Nityr™ (nitisinone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nubeqa™ (darolutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nuedexta® (dextromethorphan hydrobromide/quinidine sulfate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Nuplazid™ (pimavanserin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Odomzo® (sonidegib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Ofev® (nintedanib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Onureg® (azacitidine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Orencia® (abatacept)	Coverage for the diagnosis of rheumatoid arthritis requires trial of two of the following preferred agents: tocilizumab (Actemra®) SC, etanercept (Enbrel®), adalimumab (Humira®), or tofacitinib (Xeljanz®/Xeljanz® XR). Coverage for the diagnosis of juvenile idiopathic arthritis requires trial of two of the following preferred agents: tocilizumab (Actemra®) SC, etanercept (Enbrel®) or adalimumab (Humira®). Coverage for the diagnosis of psoriatic arthritis requires trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®), apremilast (Otezla®), ustekinumab (Stelara®), or tofacitinib (Xeljanz®/Xeljanz® XR). *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Orenitram ER™ (treprostinil diolamine)	Coverage is provided for the diagnosis of pulmonary arterial hypertension. Requires trial and failure or contraindication to inhaled treprostinil and sildenafil. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Orgovyx™ (relugolix)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Orkambi® (ivacaftor/lumacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Otezla® (apremilast)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Oxbryta™ (voxelotor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Oxervate™ (cenegermin-bkbj)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Padcev™ (enfortumab vedotin-ejfv)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Palynziq™ (pegvaliase-pqpz)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pancreaze® (pancrelipase microtablets)	Coverage requires trial or intolerance to Creon®. **Coverage duration:** Lifetime.
Pemazyre™ (pemigatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Perseris™ (risperidone)	Coverage requires a trial of oral risperidone. **Coverage duration:** Lifetime.
Piqray® (alpelisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Plegridy® (peginterferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Polivy™ (polatuzumab vedotin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pomalyst® (pomalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Praluent® (alirocumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Prolia® (denosumab)	Prolia® is subject to Part B versus Part D review. Coverage requires the patient has tried and failed at least one bisphosphonate except when: 1. There is a contraindication to an oral and intravenous bisphosphonate (such as a stricture or aclasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration), 2. There is a documented intolerance to a bisphosphonate. *All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for a diagnosis of hypocalcemia. **Coverage duration:** 1 year.
Promacta® (eltrombopag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pulmonary Arterial Hypertension (PAH) agents **Adcirca® (g)** (alyq™, tadalafil), **Letairis® (g)** (ambrisentan), **Opsumit®** (macitentan), **Revatio® (g)** (sildenafil citrate), **Tracleer® (g)** (bosentan)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for sildenafil and tadalafil in situations where patients are receiving nitrate therapy. **Coverage duration:** 1 year.
Qinlock™ (ripretinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Ravicti® (glycerol phenylbutyrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Rebif® (interferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Relistor® (methylnaltrexone)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Exclusion criteria:** Coverage is not provided for patients with known or suspected mechanical gastrointestinal obstruction. **Coverage duration:** 3 months.
Repatha® (evolocumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Retevmo™ (selpercatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Revcovi™ (elapegademase-lvlr)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Revlimid® (lenalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by an oncologist or hematologist. **Coverage duration:** 1 year.
Rexulti® (brexpiprazole)	Coverage requires trial or intolerance to Abilify Maintena or oral aripiprazole. **Coverage duration:** Lifetime.
Risperdal Consta® (risperidone)	Coverage requires the trial of oral risperidone. **Coverage duration:** Lifetime.
Rozlytrek™ (entrectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Rubraca™ (rucaparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ruzurgi® (amifampridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Rybrevant™ (amivantamab-vmjw)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Rydapt® (midostaurin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Rylaze™ (asparaginase erwinia chrysanthemi-rywn)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Samsca® (g) (tolvaptan)	Coverage requires documentation that the member does not have underlying liver disease. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 month.
Sarclisa® (isatuximab-irfc)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Savella® (milnacipran)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Simponi® (golimumab)	Coverage is provided for the diagnosis of rheumatoid arthritis when there has been a trial of two of the following preferred agents: tocilizumab (Actemra®) SC, etanercept (Enbrel®), adalimumab (Humira®), tofacitinib (Xeljanz®/Xeljanz® XR). Coverage is provided for the diagnosis of ankylosing spondylitis when there has been a trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®). Coverage is provided for the diagnosis of psoriatic arthritis when there has been a trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®), apremilast (Otezla®), ustekinumab (Stelara®), or tofacitinib (Xeljanz®/Xeljanz® XR). Coverage is provided for the diagnosis of ulcerative colitis when there has been a trial of adalimumab (Humira®) or tofacitinib (Xeljanz®). *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sirturo™ (bedaquiline fumarate)	Coverage is provided when used in combination with at least 3 other agents. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Somavert® (pegvisomant)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Sovaldi® (sofosbuvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Sprycel® (dasatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Stelara® (ustekinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sutent® (sunitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by an oncologist. **Coverage duration:** 1 year.
Tabrecta™ (capmatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tafinlar® (dabrafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tagrisso™ (osimertinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Taltz® (ixekizumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Talzenna™ (talazoparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tarceva® (g) (erlotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by an oncologist. **Coverage duration:** 1 year.
Targretin® (g) (bexarotene)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by an oncologist or dermatologist. **Coverage duration:** 1 year.
Tasigna® (nilotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tazverik™ (tazemetostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tecfidera™ (g) (dimethyl fumarate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Tegsedi™ (inotersen)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tepmetko® (tepotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Testosterone **Androgel® (g)** (testosterone) **Aveed™** (testosterone undecanoate) **Axiron® (g)** (testosterone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Thalomid® (thalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tibsovo® (ivosidenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tivdak™ (tisotumab vedotin-tftv)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Topical Non-Steroidal Anti-Inflammatories **Flector® (g)** (diclofenac epolamine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 month.
Trikafta™ (elexacaftor/tezacaftor/ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Trodelvy™ (sacituzumab govitecan-hziy)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Truseltiq™ (infigratinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tukysa™ (tucatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Turalio™ (pexidartinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ubrelvy™ (ubrogepant)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ukoniq™ (umbralisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Uloric® (g) (febuxostat)	Coverage requires trial or contraindication to allopurinol. **Coverage duration:** Lifetime.
Uptravi® (selexipag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Vecamyl™ (mecamylamine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Venclexta™ (venetoclax)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Verzenio™ (abemaciclib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vitrakvi® (larotrectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vizimpro® (dacomitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Votrient® (pazopanib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by an oncologist. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Vyndamax™ (tafamidis)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vyndaqel® (tafamidis meglumine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vyvanse® (lisdexamfetamine dimesylate)	Coverage is provided for the diagnosis of attention deficit hyperactivity disorder (ADHD). Coverage requires the failure or intolerance to methylphenidate and an amphetamine-based product. *All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** 6 years or older **Exclusion Criteria:** Patients with uncontrolled cardiovascular disease, hyperthyroidism, history of drug abuse or agitated states. **Coverage Duration:** 1 Year.
Welireg™ (belzutifan)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xalkori® (crizotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xcopri® (cenobamate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Xeljanz®, Xeljanz® XR (tofacitnib citrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xenazine® (g) (tetrabenazine)	Coverage requires documentation of the patient's CYP2D6 genotype for doses above 50mg per day. *All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided in the following situations, 1) Patients with hepatic function impairment, 2) Patients who are actively suicidal or who have untreated or inadequately treated depression, 3) Patients taking monoamine oxidase inhibitors or reserpine. **Coverage duration:** 1 year.
Xermelo® (telotristat ethyl)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xgeva® (denosumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xolair® (omalizumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xospata® (gilteritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Xpovio™ (selinexor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xtandi® (enzalutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xyrem® (sodium oxybate)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for patients taking sedative hypnotics or in patients with succinic semialdehyde dehydrogenase deficiency. **Coverage duration:** 1 year.
Yonsa® (abiraterone acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zejula™ (niraparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Zelboraf® (vemurafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided in combination with Yervoy®. **Coverage duration:** 1 year.
Zenpep® (pancrelipase delayed release)	Coverage requires trial or intolerance to Creon®. **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Zepzelca™ (lurbinectedin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zokinvy™ (lonafarnib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zolinza® (vorinostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zydelig™ (idelalisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zykadia™ (ceritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Zynlonta™ (loncastuximab tesirine-lpyl)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zytiga® (g) (abiraterone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.