Blue Cross Blue Shield Blue Care Network of Michigan

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Medicare Plus Blue℠ Group PPO and Prescription Blue℠ Group PDP
Standard Comprehensive Formulary and Standard 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.
Actimmune® (interferon gamma-1b)	*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.
Aimovig® (erenumab-aooe)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ajovy® (fremanezumab-vfrm)	*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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
Androgel® (g) (testosterone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Antidepressants **Trintellix®** (voritoxetine) **Desvenlafaxine ER** **Fetzima™** (levomilnacipran) **Fetzima™ titration pack** (levominacipran) **Paxil® oral suspension** (paroxetine) **Viibryd®** (vilazodone HCl)	Coverage requires the trial of at least 2 formulary generic antidepressants. **Coverage duration:** Lifetime.
Antipsychotic Agents **Caplyta®** (lumateperone) **Fanapt®** (iloperidone) **Geodon®** (ziprasidone) **Latuda®** (lurasidone) **Lybalvi™** (olanzapine/samidorphan) **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.
Apokyn® (apomorphine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Aptiom® (eslicarbazepine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.
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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Banzel® (g) (rufinamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Benlysta® (belimumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
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.
Caprelsa® (vandetanib)	*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.
Cerdelga® (eliglustat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Cholbam® (cholic acid)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Clomiphene	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year. ***For Group Standard Enhanced Formulary Only*** Coverage is also provided for the treatment of female infertility.
Cometriq® (cabozantinib s-malate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Copaxone® (g) (Glatopa, 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.
Cotellic™ (cobimetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Cystaran® (cysteamine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Daliresp® (roflumilast)	Coverage is provided for the treatment of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis in patients with a history of exacerbations. Patient must be receiving the following: an 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 an inhaled corticosteroid (for example, fluticasone), OR if the patient has experienced intolerance or has contraindications to the use of these medications. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Danyelza® (naxitamab-gqgk)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Dovonex® (g) (calcipotriene)	Coverage requires trial of at least one generic topical steroid. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Drizalma Sprinkle™ (duloxetine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Emsam® (selegiline transdermal system)	*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.
Endari™ (L-glutamine)	*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.
Enspryng™ (satralizumab-mwge)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Entresto® (sacubitril/valsartan)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
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.* **Prescribers 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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Exjade® (g) (deferasirox)	*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.
Farydak® (panobinostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Fazaclo ODT (g) (clozapine orally disintegrating tablet)	*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.
Firdapse® (amifampridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
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.
Fycompa® (perampanel)	*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®, Serostim®**	*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 .

MEDICATION/ DRUG CLASS	CRITERIA
High Risk Drugs **Elavil® (g)** (amitriptyline hydrochloride) **Anafranil™ (g)** (clomipramine hydrochloride) doxepin hydrochloride **Tofranil™ (g)** (imipramine hydrochloride) imipramine pamoate thioridazine hydrochloride **Surmontil® (g)** (trimipramine maleate)	High risk tricyclic antidepressants are approved if patient has a history of use. For patients initiating therapy, the high risk tricyclic antidepressant is approved if at least one of the suggested alternatives (nortriptyline, desipramine, citalopram, escitalopram, mirtazapine, sertraline, venlafaxine) with less sedation and fewer anticholinergic effects have been tried and failed or are not appropriate or contraindicated for the intended use. Thioridizine is covered for patients who have a history of use. For patients initiating therapy, thioridizine is covered if patient has a failure of or intolerance to at least one other safer alternative antipsychotic such as aripiprazole or quetiapine. *All medically accepted indications not otherwise excluded from Part D.* **Age Restriction:** Authorization is required for members 65 years of age and older. **Coverage duration:** 1 year.
Humalog® U200 (Insulin Lispro)	Coverage requires the trial or intolerance to Novolog® 70/30 or Novolog®. **Coverage duration:** Lifetime.
Humira® (adalimumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Idhifa® (enasidenib)	*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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Invega Trinza™ (paliperidone palmitate)	Coverage requires the trial of oral paliperidone or oral risperidone. **Coverage duration:** Lifetime.
Iressa® (gefitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Isotretinoin **(Accutane® (g), Amnesteem® (g), Claravis™ (g), Myorisan® (g), Zenatane™ (g))**	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Jadenu® (g) (deferasirox)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.
Jynarque™ (tolvaptan)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Kalydeco™ (ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Ketoconazole Oral Tablet	*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.
Kuvan® (g) (sapropterin)	Authorization will be renewed if patient shows improvement after initial therapy of 2 months. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Initial: 2 months. Authorization will be extended for 1 year if there is a documented response after initial therapy.
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.
Lupron Depot® (g) (leuprolide acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Lynparza™ (olaparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.
Meprobamate	*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

MEDICATION/ DRUG CLASS	CRITERIA
Myalept® (metreleptin)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions**: Prescribing physician must be an endocrinologist. **Coverage duration:** 1 year.
Namenda® (g), Namenda XR® (g) (memantine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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)**	*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.
Nayzilam® (midazolam)	*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.

MEDICATION/ DRUG CLASS	CRITERIA
Ninlaro® (ixazomib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Nityr™ (nitisinone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nivestym® (filgrastim-aafi)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Northera® (g) (droxidopa)	*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.
Nucala® (mepolizumab)	*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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
Onfi® (g) (clobazam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year
Onureg® (azacitidine)	*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.
Orfadin® (nitisinone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Orgovyx™ (relugolix)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Orkambi® (ivacaftor/lumacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
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.
Panretin® (alitretinoin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pemazyre™ (pemigatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Perseris™ (risperidone)	Coverage requires a trial of oral risperidone. **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Phenobarbital	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Piqray® (alpelisib)	*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.
Pretomanid	*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.

MEDICATION/ DRUG CLASS	CRITERIA
Qualaquin® (g) (quinine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Qinlock™ (ripretinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Revcovi™ (elapegademase-lvlr)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Rydapt® (midostaurin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Rylaze™ (asparaginase erwinia chrysanthemi-rywn)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sabril® (g) (vigabatrin)	*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.
Sandostatin® (g) (octreotide acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
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
Signifor® (pasireotide)	*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.
Somatuline® Depot (lanreotide)	*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.
Soriatane® (g) (acitretin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sovaldi® (sofosbuvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Spritam® (levetiracetam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sprycel® (dasatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Stelara® (ustekinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Stivarga® (regorafenib)	*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:** Prescribing physician must be an oncologist. **Coverage duration:** 1 year.
SymlinPen® (pramlintide)	Coverage is provided for patients that have failed intensive treatment with insulin monotherapy and for concurrent use with an insulin product. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Sympazan® (clobazam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Synribo® (omacetaxine mepesuccinate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Syprine® (g) (trientine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Tabloid® (thioguanine)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing physician must be an hematologist or 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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
Tazorac® (g) (tazarotene)	*All medically accepted indications not otherwise excluded from Part D.* **Coveage 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.
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.
Thalomid® (thalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
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 Tretinoin Products **Atralin™ (g)** **Avita® (g)** **Retin-A® (g)** (tretinoin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Trelstar® (triptorelin pamoate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Trikafta™ (elexacaftor/tezacaftor/ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Turalio™ (pexidartinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tykerb® (g) (lapatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tymlos® (abaloparatide)	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 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. Documented intolerance to a bisphosphonate. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year with a maximum of 2 years of therapy.
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 of allopurinol. **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Valchlor® (mechlorethamine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Valtoco® (diazepam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Veltassa® (patiromer)	*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.
Versacloz® (clozapine)	*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.
Vfend® (g) (voriconazole)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vigadrone® (g) (vigabatrin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Vimpat® (lacosamide)	*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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Vytorin® (g) (simvastatin/ezetimibe)	Coverage requires trial with simvastatin and ezetimibe as individual agents when used concomitantly. **Coverage duration:** Lifetime.
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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
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.
Xifaxan® (rifaximin)	*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.
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.

MEDICATION/ DRUG CLASS	CRITERIA
Zarxio™ (filgrastim-sndz)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zavesca® (g) (miglustat)	*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.
Zepzelca™ (lurbinectedin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zenpep® (pancrelipase delayed release)	Coverage requires trial or intolerance to Creon®. **Coverage duration:** Lifetime.
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.

MEDICATION/ DRUG CLASS	CRITERIA
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.