

**Medicare Plus Blue<sup>SM</sup> Group PPO and Prescription Blue<sup>SM</sup> Group PDP  
Standard Comprehensive Formulary and Standard Enhanced  
Comprehensive Formulary  
Prior Authorization / Step Therapy Program  
2024 Plan Year  
Updated 12/1/2024**

BCBSM – Medicare Plus Blue Group PPO and Prescription Blue Group PDP 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.

Y0074\_Grp24STDPAST\_C FVNR 1124

Effective Date: 12/01/2024

Last Updated: November 2024

## ACITRETIN

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### Products Affected

- Acitretin

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

## ACTIMMUNE

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### Products Affected

- Actimmune INJ 100MCG/0.5ML

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

## ADEMPAS

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### Products Affected

- Adempas

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

## ADLARITY

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### Products Affected

- Adlarity

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	COVERAGE REQUIRES A TRIAL OF GENERIC ORAL DONEPEZIL.

## AFINITOR

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### Products Affected

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

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

Effective Date: 12/01/2024

Last Updated: November 2024

# AFINITOR DISPERZ

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**Products Affected**

- Everolimus TBSO

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

## AIMOVIG

### Products Affected

- Aimovig

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	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).

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# AKEEGA

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**Products Affected**

- Akeega

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

## ALECENSA

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### Products Affected

- Alecensa

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

## ALOSETRON

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### Products Affected

- Alosetron Hydrochloride

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

## ALPHA-1-PROTEINASE INHIBITORS

### Products Affected

- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PATIENTS MUST HAVE A DIAGNOSIS OF NECROTIZING PANNICULITIS OR ALPHA-1 ANTITRYPSIN DEFICIENCY WITH AN FEV1 LESS THAN OR EQUAL 80% PREDICTED.
Age Restrictions	PATIENTS 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	N/A
Coverage Duration	1YEAR
Other Criteria	DOCUMENTATION OF A CONGENITAL DEFICIENCY OF ALPHA-1 ANTITRYPSIN CONSISTENT WITH PHENOTYPES PIZZ, PIZ (NULL), OR PI (NULL, NULL) OF AAT, AND MUST HAVE SYMPTOMATIC EMPHYSEMA.

Effective Date: 12/01/2024

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## ALUNBRIG

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### Products Affected

- Alunbrig TABS

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

Effective Date: 12/01/2024

Last Updated: November 2024

## APOKYN

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### Products Affected

- Apomorphine Hydrochloride INJ

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	COVERAGE REQUIRES TRIAL OF CARBIDOPA/LEVODOPA ER (EXTENDED RELEASE).

Effective Date: 12/01/2024

Last Updated: November 2024

## APTiom

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### Products Affected

- Aptiom

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	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

Effective Date: 12/01/2024

Last Updated: November 2024

## ARCALYST

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### Products Affected

- Arcalyst

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	COVERAGE FOR THE TREATMENT OF RECURRENT PERICARDITIS REQUIRES A TRIAL OF A NONSTEROIDAL ANTI-INFLAMMATORY DRUG IN COMBINATION WITH COLCHICINE.

Effective Date: 12/01/2024

Last Updated: November 2024



# AUBAGIO

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**Products Affected**

- Teriflunomide

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	One Year
Other Criteria	N/A

## AUGTYRO

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### Products Affected

- Augtyro CAPS 40MG

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

Effective Date: 12/01/2024

Last Updated: November 2024

## AVONEX

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### Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

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

Effective Date: 12/01/2024

Last Updated: November 2024

## AYVAKIT

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### Products Affected

- Ayvakit

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	One Year
Other Criteria	N/A

## BALVERSA

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### Products Affected

- Balversa

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

## BANZEL

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### Products Affected

- Rufinamide

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

## BENLYSTA

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### Products Affected

- Benlysta INJ 200MG/ML

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

Effective Date: 12/01/2024

Last Updated: November 2024

## BESREMI

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### Products Affected

- Besremi

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



## BETASERON

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### Products Affected

- Betaseron

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

## BOSULIF

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### Products Affected

- Bosulif

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

## BRAFTOVI

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### Products Affected

- Braftovi CAPS 75MG

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

Effective Date: 12/01/2024

Last Updated: November 2024

## BRIVIACT

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### Products Affected

- Briviact SOLN
- Briviact TABS

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	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

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Last Updated: November 2024

## BRONCHITOL

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### Products Affected

- Bronchitol

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

## BRUKINSA

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### Products Affected

- Brukinsa

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

## CABLIVI

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### Products Affected

- Cablivi

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

## CABOMETYX

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### Products Affected

- Cabometyx

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



## CALCIPOTRIENE

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### Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN

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	REQUIRES TRIAL OF AT LEAST ONE GENERIC TOPICAL STEROID.

Effective Date: 12/01/2024

Last Updated: November 2024

# CALQUENCE

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**Products Affected**

- Calquence

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

## CAMZYOS

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### Products Affected

- Camzyos

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

## CAPRELSA

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### Products Affected

- Caprelsa

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

## CAYSTON

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### Products Affected

- Cayston

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

## CERDELGA

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### Products Affected

- Cerdelga

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

# CHOLBAM

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**Products Affected**

- Cholbam

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

# CIALIS

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**Products Affected**

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	REQUIRES THE DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	N/A



## CLOMIPHENE

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### Products Affected

- Clomid
- Clomiphene Citrate TABS

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	*For Group Standard Enhanced Formulary Only* Coverage is also provided for the treatment of female infertility.

Effective Date: 12/01/2024

Last Updated: November 2024

## CLOZAPINE ODT

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### Products Affected

- Clozapine Odt

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

# COMETRIQ

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**Products Affected**

- Cometriq

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	Authorization will be for 12 months.
Other Criteria	N/A

## COPAXONE

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### Products Affected

- Glatiramer Acetate
- Glatopa

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

Effective Date: 12/01/2024

Last Updated: November 2024

## COPIKTRA

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### Products Affected

- Copiktra

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

## 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>

Effective Date: 12/01/2024

Last Updated: November 2024

## COTELLIC

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### Products Affected

- Cotellic

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



## CYSTARAN

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### Products Affected

- Cystaran

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

## 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.

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# DANYELZA

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**Products Affected**

- Danyelza

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

# DAURISMO

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**Products Affected**

- Daurismo

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

## DAYBUE

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### Products Affected

- Daybue

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

Effective Date: 12/01/2024

Last Updated: November 2024

# DEFERASIROX

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**Products Affected**

- Deferasirox TBSO

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

## DIACOMIT

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### Products Affected

- Diacomit

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	One Year
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

Effective Date: 12/01/2024

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## DIHYDROERGOTAMINE NASAL SPRAY

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### Products Affected

- Dihydroergotamine Mesylate SOLN

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	COVERAGE REQUIRES TRIAL OF TWO TRIPTANS ON THE FORMULARY: ONE ORAL TRIPTAN AND ONE NON-ORAL TRIPTAN (SUCH AS NASAL SPRAY OR INJECTION).

Effective Date: 12/01/2024

Last Updated: November 2024



## DOJOLVI

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### Products Affected

- Dojolvi

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	One Year
Other Criteria	N/A

## DOPTELET

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### Products Affected

- Doptelet

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

Effective Date: 12/01/2024

Last Updated: November 2024

## DRIZALMA SPRINKLE

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### Products Affected

- Drizalma Sprinkle

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

Effective Date: 12/01/2024

Last Updated: November 2024

## DULERA

### Products Affected

- Dulera

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	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## **DUPIXENT**

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### **Products Affected**

- Dupixent

Prior Authorization Criteria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	EOE: PATIENT MUST WEIGH AT LEAST 15 KILOGRAMS
Age Restrictions	AD: AT LEAST 6 MONTHS OF AGE. EA, CDA: AT LEAST 6 YEARS OF AGE. EOE: AT LEAST 1 YEAR OF AGE. PN: AT LEAST 12 YEARS OF AGE. CRSWNP: AT LEAST 12 YEARS OF AGE.
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	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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	(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.
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## EMGALITY

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### Products Affected

- Emgality

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	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).

Effective Date: 12/01/2024

Last Updated: November 2024



## EMSAM

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### Products Affected

- Emsam

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

## ENBREL

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### Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

## Prior Authorization Criteria

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	One Year
Other Criteria	<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 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>

Effective Date: 12/01/2024

Last Updated: November 2024

## ENDARI

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### Products Affected

- Endari
- L-glutamine PACK

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

Effective Date: 12/01/2024

Last Updated: November 2024

## ENHERTU

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### Products Affected

- Enhertu

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

## EPCLUSA

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### Products Affected

- Epclusa

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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Effective Date: 12/01/2024

Last Updated: November 2024

## EPIDIOLEX

### Products Affected

- Epidiolex

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	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## EPRONTIA

### Products Affected

- Eprontia

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	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

Effective Date: 12/01/2024

Last Updated: November 2024



## ERIVEDGE

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### Products Affected

- Erivedge

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	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST OR DERMATOLOGIST
Coverage Duration	1 YEAR
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

# ERLEADA

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**Products Affected**

- Erleada

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

## 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
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	THREE MONTHS
Other Criteria	ERYTHROPOIESIS STIMULATING AGENTS ARE SUBJECT TO PART B VS PART D REVIEW.

Effective Date: 12/01/2024

Last Updated: November 2024

## ESBRIET

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### Products Affected

- Pirfenidone CAPS
- Pirfenidone TABS 267MG, 801MG

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

## EXKIVITY

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### Products Affected

- Exkivity

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

## FARYDAK

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### Products Affected

- Farydak

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

## **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 6 YEARS OF AGE OR OLDER. COVERAGE FOR EA ALSO REQUIRES CONCURRENT STANDARD OF CARE REGIMEN. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Effective Date: 12/01/2024

Last Updated: November 2024



## FILSPARI

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### Products Affected

- Filspari

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	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

Effective Date: 12/01/2024

Last Updated: November 2024

## FILSUEVZ

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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

Effective Date: 12/01/2024

Last Updated: November 2024

## FINTEPLA

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### Products Affected

- Fintepla

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	COVERAGE REQUIRES THE TRIAL OF TWO OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, TOPIRAMATE.

Effective Date: 12/01/2024

Last Updated: November 2024

# FIRAZYR

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**Products Affected**

- Icatibant Acetate
- Sajazir

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	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

# FORTEO

## Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 YEARS
Other Criteria	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## FOTIVDA

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### Products Affected

- Fotivda

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

## FRUZAQLA

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### Products Affected

- Fruzaqla

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

## FYCOMPA

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### Products Affected

- Fycompa

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	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

Effective Date: 12/01/2024

Last Updated: November 2024



## GATTEX

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### Products Affected

- Gattex

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

Effective Date: 12/01/2024

Last Updated: November 2024

## GAVRETO

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### Products Affected

- Gavreto

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	One Year
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

# GILENYA

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**Products Affected**

- Fingolimod Hydrochloride

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

## GILOTRIF

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### Products Affected

- Gilotrif

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

## GLP-1 AGONISTS

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### Products Affected

- Bydureon Bcise
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	EXCLUDED IF USED FOR THE TREATMENT OF WEIGHT LOSS ONLY
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

## 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
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	PEDIATRICS EQUALS ONE YEAR. ADULTS EQUALS LIFETIME
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

# HAEGARDA

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**Products Affected**

- Haegarda

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	6 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

## HARVONI

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### Products Affected

- Harvoni

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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Effective Date: 12/01/2024

Last Updated: November 2024



## HEMADY

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### Products Affected

- Hemady

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

## HETLIOZ

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### Products Affected

- Tasimelteon

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

## 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

Effective Date: 12/01/2024

Last Updated: November 2024

Prior Authorization Criteria

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	One Year
Other Criteria	<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 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-MERCAPTOPYRINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE), METHOTREXATE</p>

Effective Date: 12/01/2024

Last Updated: November 2024

	(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-MERCAPTOPURINE (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.
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## HYFTOR

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### Products Affected

- Hyftor

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

## IBRANCE

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### Products Affected

- Ibrance

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

## ICLUSIG

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### Products Affected

- Iclusig

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	Authorization will be for 12 months.
Other Criteria	N/A



# IDHIFA

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**Products Affected**

- Idhifa

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

## IMBRUVICA

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### Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 420MG, 560MG

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

Effective Date: 12/01/2024

Last Updated: November 2024

## IMVEXXY

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### Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

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

## INCRELEX

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### Products Affected

- Increlex

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

## INLYTA

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### Products Affected

- Inlyta

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

## INQOVI

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### Products Affected

- Inqovi

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	One Year
Other Criteria	N/A

# INREBIC

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**Products Affected**

- Inrebic

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

## IRESSA

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### Products Affected

- Gefitinib

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



## ISOTRETINOIN

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### Products Affected

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

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	COVERAGE REQUIRES THE TRIAL OF EITHER AN ORAL ANTIBIOTIC OR A BENZOYL PEROXIDE CONTAINING TOPICAL THERAPY.

Effective Date: 12/01/2024

Last Updated: November 2024

## IVERMECTIN

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### Products Affected

- Ivermectin TABS

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

## IWILFIN

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### Products Affected

- Iwilfin

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

# JADENU

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**Products Affected**

- Deferasirox TABS

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

# JAKAFI

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**Products Affected**

- Jakafi

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	1YEAR
Other Criteria	N/A

# JAYPIRCA

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**Products Affected**

- Jaypirca

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

## JOENJA

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**Products Affected**

- Joenja

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	FOR TREATMENT OF ACTIVATED PHOSPHOINOSITIDE 3-KINASE DELTA SYNDROME (APDS): CANNOT BE USED IN COMBINATION WITH AN IMMUNOSUPPRESSIVE MEDICATION.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

## KALYDECO

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### Products Affected

- Kalydeco

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



## KERENDIA

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### Products Affected

- Kerendia

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

## KETOCONAZOLE

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### Products Affected

- Ketoconazole TABS

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

## KEVZARA

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### Products Affected

- Kevzara

Prior Authorization Criteria

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	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. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND TRIAL OF TWO OF THE FOLLOWING: ENBREL, HUMIRA, XELJANZ/XR, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Effective Date: 12/01/2024

Last Updated: November 2024

# KINERET

## Products Affected

- Kineret

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	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## KISQALI

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### Products Affected

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

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

## KORLYM

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### Products Affected

- Korlym
- Mifepristone TABS 300MG

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

# KOSELUGO

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**Products Affected**

- Koselugo

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	One Year
Other Criteria	N/A



# KRAZATI

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**Products Affected**

- Krazati

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

## LAZCLUZE

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### Products Affected

- Lazcluze

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	1YEAR
Other Criteria	COVERAGE FOR TREATMENT LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES COMBINATION USE WITH AMIVANTAMAB.

Effective Date: 12/01/2024

Last Updated: November 2024

## 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
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

Effective Date: 12/01/2024

Last Updated: November 2024

## 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  
11.25MG, 7.5MG
- Lupron Depot-ped (3-month) INJ  
11.25MG

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

Effective Date: 12/01/2024

Last Updated: November 2024

## LIBERVANT

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### Products Affected

- Libervant

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

## LIBTAYO

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### Products Affected

- Libtayo

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

## LIDOCAINE TOPICALS

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### Products Affected

- Lidocaine PTCH 5%
- Lidocaine/prilocaine CREA

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	3 YEARS
Other Criteria	N/A

# LIVTENCITY

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**Products Affected**

- Livtencity

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



## LONSURF

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### Products Affected

- Lonsurf

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

## LORBRENA

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### Products Affected

- Lorbrena

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

## LUMAKRAS

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### Products Affected

- Lumakras

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

# LUMOXITI

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**Products Affected**

- Lumoxiti

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

# LYNPARZA

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**Products Affected**

- Lynparza TABS

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

## LYTGOBI

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### Products Affected

- Lytgobi

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

## MARGENZA

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### Products Affected

- Margenza

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

# MEKINIST

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**Products Affected**

- Mekinist TABS

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



# MEKINIST LIQUID FORMULATION

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**Products Affected**

- Mekinist SOLR

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	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.

## MEKTOVI

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### Products Affected

- Mektovi

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

## MEMANTINE

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### Products Affected

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

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	PRIOR AUTHORIZATION APPLIES ONLY TO PATIENTS LESS THAN 30 YEARS OF AGE.

Effective Date: 12/01/2024

Last Updated: November 2024

## MEPROBAMATE

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### Products Affected

- Meprobamate

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

# MIGLUSTAT

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**Products Affected**

- Miglustat
- Yargesa

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

## MONJUVI

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### Products Affected

- Monjuvi

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

## MOTPOLY XR

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### Products Affected

- Motpoly Xr

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	COVERAGE FOR SEIZURES REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANT ALTERNATIVES, ONE OF WHICH MUST BE GENERIC LACOSAMIDE.

Effective Date: 12/01/2024

Last Updated: November 2024

# MOVANTIK

## Products Affected

- Movantik

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	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 1 YEAR
Other Criteria	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.

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# MYALEPT

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**Products Affected**

- Myalept

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	One Year
Other Criteria	N/A

## NARCOLEPSY AGENTS

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### Products Affected

- Armodafinil
- Modafinil TABS

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

## NARCOTIC ANALGESICS

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### Products Affected

- Fentanyl Citrate Oral Transmucosal

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

## NATPARA

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### Products Affected

- Natpara

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

## NAYZILAM

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### Products Affected

- Nayzilam

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

## NERLYNX

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### Products Affected

- Nerlynx

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

## NEXAVAR

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### Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

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

## NINLARO

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### Products Affected

- Ninlaro

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



## NIVESTYM

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### Products Affected

- Nivestym

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

## NORTHERA

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### Products Affected

- Droxidopa

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	COVERAGE REQUIRES A TRIAL OF MIDODRINE AND FLUDROCORTISONE.

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## NUBEQA

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### Products Affected

- Nubeqa

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

## NUCALA

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### **Products Affected**

- Nucala

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 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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	<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

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

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Last Updated: November 2024

## NUPLAZID

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### Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

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

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Last Updated: November 2024



## OCTREOTIDE ACETATE

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### Products Affected

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

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

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Last Updated: November 2024

## ODOMZO

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### Products Affected

- Odomzo

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

## OFEV

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### Products Affected

- Ofev

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

## OGSIVEO

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### Products Affected

- Ogsiveo

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

## OJEMDA

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### Products Affected

- Ojemda TABS

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

## OJEMDA LIQUID FORMULATION

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### Products Affected

- Ojemda SUSR

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	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.

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Last Updated: November 2024

## OJJAARA

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### Products Affected

- Ojjaara

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

## ONUREG

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### Products Affected

- Onureg

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	One Year
Other Criteria	N/A



## OPFOLDA

### Products Affected

- Opfolda

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

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Last Updated: November 2024

## ORENCIA

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### **Products Affected**

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

## 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 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>	One 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 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).

Effective Date: 12/01/2024

Last Updated: November 2024

## ORENITRAM ER

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### Products Affected

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

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	COVERAGE IS PROVIDED FOR THE DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION. REQUIRES TRIAL AND FAILURE OR CONTRAINDICATION TO INHALED TREPROSTINIL AND SILDENAFIL.

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Last Updated: November 2024

## ORFADIN

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### Products Affected

- Nitisinone
- Orfadin SUSP

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

## ORGOVYX

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### Products Affected

- Orgovyx

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	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO FIRMAGON. FOR MA-PD PLANS, THE TRIAL OF FIRMAGON MAY BE PART B VEFOR PART D STEP THERAPY.

Effective Date: 12/01/2024

Last Updated: November 2024

## ORKAMBI

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### Products Affected

- Orkambi

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

## ORSERDU

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### Products Affected

- Orserdu

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



## OTEZLA

### Products Affected

- Otezla

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

Effective Date: 12/01/2024

Last Updated: November 2024

## OXBRYTA

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### Products Affected

- Oxbryta

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	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO HYDROXYUREA.

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Last Updated: November 2024

# PADCEV

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**Products Affected**

- Padcev

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

## PANRETIN

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### Products Affected

- Panretin

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

# PEMAZYRE

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**Products Affected**

- Pemazyre

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	One Year
Other Criteria	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

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Last Updated: November 2024

## PIQRAY

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### Products Affected

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

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	One Year
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

## POLIVY

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### Products Affected

- Polivy

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



# POMALYST

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**Products Affected**

- Pomalyst

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

## PRETOMANID

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### Products Affected

- Pretomanid

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

## PROLIA

### Products Affected

- Prolia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE IS NOT PROVIDED FOR HYPOCALCEMIA.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	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.

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Last Updated: November 2024

## PROMACTA

### Products Affected

- Promacta TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ITP REQUIRES TRIAL OF CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY

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## PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

### Products Affected

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

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

Effective Date: 12/01/2024

Last Updated: November 2024

## PYRUKYND

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### Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

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

## QINLOCK

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### Products Affected

- Qinlock

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	One Year
Other Criteria	N/A

## QUININE

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### Products Affected

- Quinine Sulfate CAPS 324MG

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



## QULIPTA

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### Products Affected

- Qulipta

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	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).

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## RADICAVA ORS

### Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	ALS: MUST BE PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	1 year
Other Criteria	RENEWAL REQUIRES SUBMISSION OF PATIENT ASSESSMENTS USING THE ALSFRS-R OR OTHER CLINICAL DOCUMENTATION TO DETERMINE IF RADICAVA IS SLOWING THE PROGRESSION OF ALS.

Effective Date: 12/01/2024

Last Updated: November 2024

## RAVICTI

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### Products Affected

- Ravicti

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

## REBIF

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### Products Affected

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

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	COVERAGE REQUIRES TRIAL OF AVONEX OR BETASERON

Effective Date: 12/01/2024

Last Updated: November 2024

## RECORLEV

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### Products Affected

- Recorlev

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	COVERAGE REQUIRES A TRIAL OF KETOCONAZOLE, MITOTANE, OR CABERGOLINE.

Effective Date: 12/01/2024

Last Updated: November 2024

## RELISTOR

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### Products Affected

- Relistor

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

## REPATHA

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### Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

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	3 YEARS
Other Criteria	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO ONE HIGH INTENSITY STATIN.

Effective Date: 12/01/2024

Last Updated: November 2024

## RETEVMO

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### Products Affected

- Retevmo

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	One Year
Other Criteria	N/A



## REVCovi

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### Products Affected

- Revcovi

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

## REVLIMID

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### Products Affected

- Lenalidomide
- Revlimid

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	MUST BE PRESCRIBED BY AN ONCOLOGIST OR HEMATOLOGIST
Coverage Duration	1 YEAR
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

# REXULTI

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**Products Affected**

- Rexulti

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	COVERAGE FOR A DIAGNOSIS OF SCHIZOPHRENIA REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE.

# REZLIDHIA

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**Products Affected**

- Rezlidhia

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

## REZUROCK

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### Products Affected

- Rezurock

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

## RINVOQ

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### Products Affected

- Rinvoq

## 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 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-MERCAPTOPURINE (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>

Effective Date: 12/01/2024

Last Updated: November 2024

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-MERCAPTOPURINE (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>
<b>Other Criteria</b>	<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>

Effective Date: 12/01/2024

Last Updated: November 2024



## RINVOQ LIQUID FORMULATION

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### Products Affected

- Rinvoq Lq

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>	1YEAR
<b>Other Criteria</b>	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES 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).

Effective Date: 12/01/2024

Last Updated: November 2024

## RIVFLOZA

### Products Affected

- Rivfloza

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

Effective Date: 12/01/2024

Last Updated: November 2024

## ROZLYTREK

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### Products Affected

- Rozlytrek

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	One Year
Other Criteria	N/A

## RUBRACA

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### Products Affected

- Rubraca

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

## RYBREVANT

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### Products Affected

- Rybrevant

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

# RYDAPT

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**Products Affected**

- Rydapt

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

# RYLAZE

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**Products Affected**

- Rylaze

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

## SAPROPTERIN HYDROCHLORIDE

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### Products Affected

- Sapropterin Dihydrochloride

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	INITIAL - 2 MONTHS AUTH WILL BE EXTENDED FOR 1 YEAR IF DOCUMENTED RESPONSE AFTER INITIAL THERAPY
Other Criteria	RENEWAL CRITERIA: PATIENT MUST SHOW IMPROVEMENT AFTER INITIAL THERAPY OF 2 MONTHS.

Effective Date: 12/01/2024

Last Updated: November 2024



# SARCLISA

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**Products Affected**

- Sarclisa

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

## SAVELLA

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### Products Affected

- Savella
- Savella Titration Pack

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	COVERAGE FOR A DIAGNOSIS OF FIBROMYALGIA REQUIRES A TRIAL OF GABAPENTIN.

Effective Date: 12/01/2024

Last Updated: November 2024

# SCSEMBLIX

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**Products Affected**

- Scemblix

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

# SIGNIFOR

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**Products Affected**

- Signifor

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

## SIRTURO

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### Products Affected

- Sirturo

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	MUST BE USED IN COMBINATION WITH AT LEAST 3 OTHER AGENTS.

# SKYCLARYS

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**Products Affected**

- Skyclarys

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

## SKYRIZI

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### Products Affected

- Skyrizi INJ 150MG/ML
- Skyrizi Pen

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	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## SKYRIZI 360 MG

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### Products Affected

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



## 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>	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-MERCAPTOPURINE (6-MP), IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., 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-MERCAPTOPURINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), DIPENTUM (OLSALAZINE), AZULFIDINE (SULFASALAZINE)], IMURAN (AZATHIOPRINE), CORTICOSTEROID (E.G., PREDNISONE, METHYLPREDNISOLONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Effective Date: 12/01/2024

Last Updated: November 2024

## SOHONOS

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### Products Affected

- Sohonos

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

Effective Date: 12/01/2024

Last Updated: November 2024

## SOMATULINE DEPOT

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### Products Affected

- Lanreotide Acetate
- Somatuline Depot

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

# SOMAVERT

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**Products Affected**

- Somavert

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

## SOVALDI

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### Products Affected

- Sovaldi

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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Effective Date: 12/01/2024

Last Updated: November 2024

## SPRITAM

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### Products Affected

- Spritam

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	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

Effective Date: 12/01/2024

Last Updated: November 2024

## SPRYCEL

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### Products Affected

- Dasatinib
- Sprycel

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	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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE OF 90MG/ML STRENGTH FOR A DIAGNOSIS OF PSA OR PLAQUE PSORIASIS REQUIRES PATIENT WEIGHT GREATER THAN 100KG (220LBS).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	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-MERCAPTOPURINE (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-MERCAPTOPURINE (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.

Effective Date: 12/01/2024

Last Updated: November 2024

# STIVARGA

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**Products Affected**

- Stivarga

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

## SUTENT

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### Products Affected

- Sunitinib Malate

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	MUST BE PRESCRIBED BY AN ONCOLOGIST.
Coverage Duration	1 YEAR
Other Criteria	N/A

## SYMLIN

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### Products Affected

- Symlinpen 120
- Symlinpen 60

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	SYMLIN IS COVERED FOR PATIENTS THAT HAVE FAILED INTENSIVE TREATMENT WITH INSULIN MONOTHERAPY AND FOR CONCURRENT USE WITH AN INSULIN PRODUCT.

Effective Date: 12/01/2024

Last Updated: November 2024

## SYMPAZAN

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### Products Affected

- Clobazam
- Sympazan

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

# SYNRIBO

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**Products Affected**

- Synribo

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

## TABLOID

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### Products Affected

- Tabloid

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	Prescribed by an oncologist or hematologist
Coverage Duration	One Year
Other Criteria	N/A

## TABRECTA

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### Products Affected

- Tabrecta

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	One Year
Other Criteria	N/A



# TAFINLAR

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**Products Affected**

- Tafinlar CAPS

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

## TAFINLAR LIQUID FORMULATION

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### Products Affected

- Tafinlar TBSO

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	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW CAPSULE FORMULATION.

Effective Date: 12/01/2024

Last Updated: November 2024

# TAGRISSO

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**Products Affected**

- Tagrisso

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

## TALZENNA

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### Products Affected

- Talzenna

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

# TARCEVA

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**Products Affected**

- Erlotinib Hydrochloride TABS

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	MUST BE PRESCRIBED BY AN ONCOLOGIST.
Coverage Duration	1 YEAR
Other Criteria	N/A

## TARGRETIN

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### Products Affected

- Bexarotene

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	MUST BE PRESCRIBED BY A ONCOLOGIST OR DERMATOLOGIST
Coverage Duration	1 YEAR
Other Criteria	N/A

# TASIGNA

---

**Products Affected**

- Tassigna

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	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB.

## TAZAROTENE

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### Products Affected

- Tazarotene CREA 0.1%
- Tazarotene GEL

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



## TAZVERIK

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### Products Affected

- Tazverik

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

## TECFIDERA

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### Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack  
CDPK 0

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

Effective Date: 12/01/2024

Last Updated: November 2024

# TEPMETKO

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**Products Affected**

- Tepmetko

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

## 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

Effective Date: 12/01/2024

Last Updated: November 2024

# TETRABENAZINE

## Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	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.
Required Medical Information	DOCUMENTATION OF THE CYP2D6 GENOTYPE OF THE PATIENT WILL BE REQUIRED FOR DOSES ABOVE 50MG PER DAY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

Effective Date: 12/01/2024

Last Updated: November 2024

## THALOMID

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### Products Affected

- Thalomid

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

# TIBSOVO

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**Products Affected**

- Tibsovo

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

# TIVDAK

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**Products Affected**

- Tivdak

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



## TOPICAL TRETINOIN

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### Products Affected

- Avita CREA
- Tretinoin CREA
- Tretinoin GEL

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

## TRELSTAR

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### Products Affected

- Trelstar Mixject

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

## TRIENTINE HCL

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### Products Affected

- Trientine Hydrochloride

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

# TRIKAFTA

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**Products Affected**

- Trikafta

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

# TRODELVY

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**Products Affected**

- Trodelvy

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

# TRUQAP

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**Products Affected**

- Truqap

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

# TRUSELTIQ

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**Products Affected**

- Truseltiq

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

## TUKYSA

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### Products Affected

- Tukysa

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	One Year
Other Criteria	N/A



# TURALIO

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**Products Affected**

- Turalio

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

# TYKERB

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**Products Affected**

- Lapatinib Ditosylate

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

# TYMLOS

## Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 YEARS
Other Criteria	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.

Effective Date: 12/01/2024

Last Updated: November 2024

# TYVASO DPI

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**Products Affected**

- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

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	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

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	FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN.

Effective Date: 12/01/2024

Last Updated: November 2024

## VALCHLOR

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### Products Affected

- Valchlor

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

## VALTOCO

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### Products Affected

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

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

Effective Date: 12/01/2024

Last Updated: November 2024

## VANFLYTA

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### Products Affected

- Vanflyta

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



## VENCLEXTA

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### Products Affected

- Venclexta
- Venclexta Starting Pack

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

## VEOZAH

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### Products Affected

- Veozah

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	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## VERQUVO

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### 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

Effective Date: 12/01/2024

Last Updated: November 2024

## VERSACLOZ

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### Products Affected

- Versacloz

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

## VERZENIO

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### Products Affected

- Verzenio

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

# VIGABATRIN

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**Products Affected**

- Vigabatrin

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

# VIJOICE

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**Products Affected**

- Vioice TBPK

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

# VITRAKVI

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**Products Affected**

- Vitrakvi

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



## VIVJOA

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### Products Affected

- Vivjoa

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	REQUIRES THE TRIAL OF OR INTOLERANCE TO GENERIC FLUCONAZOLE ALONE.

# VIZIMPRO

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**Products Affected**

- Vizimpro

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

## VONJO

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### Products Affected

- Vonjo

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

## VORANIGO

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### Products Affected

- Voranigo

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	1YEAR
Other Criteria	COVERAGE IS PROVIDED FOR TREATMENT OF GRADE 2 ASTROCYTOMA OR OLIGODENDROGLIOMA FOLLOWING SURGERY INCLUDING BIOPSY, SUB-TOTAL RESECTION, OR GROSS TOTAL RESECTION.

Effective Date: 12/01/2024

Last Updated: November 2024

## VORICONAZOLE

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### Products Affected

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

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

Effective Date: 12/01/2024

Last Updated: November 2024

# VOSEVI

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**Products Affected**

- Vosevi

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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

## VOTRIENT

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### Products Affected

- Pazopanib Hydrochloride
- Votrient

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	Prescribed by an oncologist
Coverage Duration	1 YEAR
Other Criteria	N/A

## VOYDEYA

### Products Affected

- Voydeya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR THE TREATMENT OF EXTRAVASCULAR HEMOLYSIS (EVH) WITH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) REQUIRES THAT THE PATIENT MUST HAVE CLINICALLY SIGNIFICANT EVH DUE TO PNH WITH THE FOLLOWING: HEMOGLOBIN (HGB) LESS THAN OR EQUAL TO 9.5 G/DL AND ABSOLUTE RETICULOCYTE COUNT GREATER THAN OR EQUAL TO $120 \times 10^9/L$ .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF EVH WITH PNH REQUIRES COMBINATION USE WITH SOLIRIS OR ULTOMIRIS ONLY.

Effective Date: 12/01/2024

Last Updated: November 2024



## WELIREG

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### Products Affected

- Welireg

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

## WINREVAIR

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### Products Affected

- Winrevair

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	COVERAGE FOR A DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION REQUIRES A TRIAL OF BOTH OF THE FOLLOWING: 1) GENERIC SILDENAFIL OR TADALAFIL AND 2) GENERIC BOSENTAN OR AMBRISENTAN

Effective Date: 12/01/2024

Last Updated: November 2024

## XALKORI

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### Products Affected

- Xalkori

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

## XCOPRI

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### Products Affected

- Xcopri

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	One Year
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.

Effective Date: 12/01/2024

Last Updated: November 2024

## XDEMZY

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### Products Affected

- Xdemzy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR DEMODEX BLEPHARITIS REQUIRES CONFIRMATION OF DIAGNOSIS OF DEMODEX BLEPHARITIS VIA THE PRESENCE OF COLLARETTES UPON EXAMINATION WITH A SLIT LAMP.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	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>	One 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 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-MERCAPTOPURINE (PURINETHOL), AMINOSALICYLATE [E.G., MESALAMINE (ASACOL, PENTASA, ROWASA), OLSALAZINE (DIPENTUM), SULFASALAZINE (AZULFIDINE, SULFAZINE)], AZATHIOPRINE (IMURAN), CORTICOSTEROIDS (E.G.,

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## Prior Authorization Criteria

	<p>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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Last Updated: November 2024



## XERMELO

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### Products Affected

- Xermelo

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	One Year
Other Criteria	N/A

## XGEVA

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### Products Affected

- Xgeva

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

## XIFAXAN

### Products Affected

- Xifaxan TABS 550MG

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	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.

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## **XOLAIR**

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### **Products Affected**

- Xolair

Prior Authorization Criteria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	<p>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</p> <p>CRSWNP: IMMUNOGLOBULIN E (IGE) LEVEL BETWEEN 30 AND 1500 IU/ML AT INITIATION OF TREATMENT</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	<p>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</p>

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Prior Authorization Criteria

	ANTIHISTAMINE, 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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Effective Date: 12/01/2024

Last Updated: November 2024

# XOSPATA

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**Products Affected**

- Xospata

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

## XPHOZAH

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### Products Affected

- Xphozah

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



## XPOVIO

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### Products Affected

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

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

Effective Date: 12/01/2024

Last Updated: November 2024

# XTANDI

## Products Affected

- Xtandi

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	COVERAGE FOR METASTATIC CASTRATION RESISTANT PROSTATE CANCER (CRPC) AND METASTATIC CASTRATION SENSITIVE PROSTATE CANCER (CSPC) REQUIRES TRIAL OF ABIRATERONE.

Effective Date: 12/01/2024

Last Updated: November 2024

## XYREM

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### Products Affected

- Sodium Oxybate
- Xyrem

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

Effective Date: 12/01/2024

Last Updated: November 2024

## ZARXIO

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### Products Affected

- Zarxio

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

# ZEJULA

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**Products Affected**

- Zejula

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

# ZELBORAF

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**Products Affected**

- Zelboraf

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

## ZEPZELCA

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### Products Affected

- Zepzelca

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

## **ZILBRYSQ**

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### **Products Affected**

- Zilbrysq



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>	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.

Effective Date: 12/01/2024

Last Updated: November 2024

## ZOLINZA

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### Products Affected

- Zolinda

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

## ZONISADE

### Products Affected

- Zonisade

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	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

Effective Date: 12/01/2024

Last Updated: November 2024

## ZTALMY

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### Products Affected

- Ztalmy

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

# ZURZUVAE

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**Products Affected**

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	60 Days
Other Criteria	N/A

# ZYDELIG

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**Products Affected**

- Zydelig

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

# ZYKADIA

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**Products Affected**

- Zykadia TABS

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

## **PART B VERSUS PART D**

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## 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
- 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
- Gammagard Liquid
- Gammaplex INJ 10GM/100ML, 20GM/200ML, 5GM/50ML
- Gamunex-c
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepilisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR

Effective Date: 12/01/2024

Last Updated: November 2024

## Prior Authorization Criteria

- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- 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
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU 300MG/5ML

Effective Date: 12/01/2024

Last Updated: November 2024

## 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 Kit
- Tyvaso Starter Kit
- Ventavis

Effective Date: 12/01/2024

Last Updated: November 2024

## **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

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME
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# ABILIFY MAINTENA

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## Products Affected

- Abilify Maintena

## Details

Criteria	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

Criteria	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

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

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**Products Affected**

- Aristada

**Details**

Criteria	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**

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.
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## HUMALOG

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### Products Affected

- Humalog Kwikpen INJ 200UNIT/ML

### Details

Criteria	REQUIRES TRIAL OR INTOLERANCE TO NOVOLOG 70/30 OR NOVOLOG.COVERAGE DURATION IS LIFETIME.
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## INVEGA HAFYERA

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### Products Affected

- Invega Hafyera

### Details

Criteria	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

Criteria	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

Criteria	REQUIRES TRIAL OF ORAL PALIPERIDONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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## PERSERIS

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### Products Affected

- Perseris

### Details

Criteria	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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## ROCKLATAN

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### Products Affected

- Rocklatan

### Details

<b>Criteria</b>	COVERAGE REQUIRES TRIAL OF AT LEAST ONE GENERIC OPHTHALMIC (EYE) MEDICATION, SUCH AS LATANOPROST (GENERIC XALATAN), BIMATOPROST (GENERIC LUMIGAN), OR TIMOLOL. COVERAGE DURATION IS 1 YEAR.
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## RYKINDO

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### Products Affected

- Rykindo

### Details

Criteria	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# RYTARY

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## Products Affected

- Rytary

## Details

Criteria	COVERAGE REQUIRES TRIAL OF GENERIC ORAL EXTENDED-RELEASE CARBIDOPA & LEVODOPA. COVERAGE DURATION IS 1 YEAR.
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## ULORIC

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### Products Affected

- Febuxostat

### Details

Criteria	REQUIRES TRIAL OR CONTRAINDICATION OF ALLOPURINOL. COVERAGE DURATION IS LIFETIME.
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## UZEDY

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### Products Affected

- Uzedy

### Details

Criteria	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.
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# VUMERITY

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**Products Affected**

- Vumerity

**Details**

Criteria	COVERAGE REQUIRES TRIAL OF DIMETHYL FUMARATE. COVERAGE DURATION IS ONE YEAR.
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# VYTORIN

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**Products Affected**

- Ezetimibe/simvastatin

**Details**

Criteria	REQUIRES TRIAL WITH SIMVASTATIN AND EZETIMIBE AS INDIVIDUAL AGENTS WHEN USED CONCOMITANTLY. COVERAGE DURATION IS LIFETIME.
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