Blue Cross Blue Shield Blue Care Network of Michigan

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

Medicare Plus Blue℠ PPO Essential, Medicare Plus Blue℠ PPO + Meijer, and Medicare Plus Blue℠ PPO + Part B Credit
Core Comprehensive Formulary
Prior Authorization / Step Therapy Program
2025 Plan Year
Updated 12/1/2025

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

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

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

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ACITRETIN

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

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

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

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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER REQUIRES COMBINATION USE WITH EXEMESTANE AND A TRIAL OF LETROZOLE OR ANASTROZOLE. COVERAGE FOR THE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRES A TRIAL OF SUNITINIB OR SORAFENIB.

AFINITOR DISPERZ

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	N/A

AKEEGA

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	COVERAGE FOR THE TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS BRCA-MUTATED (BRCAM) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES COMBINATION USE WITH PREDNISONE.

ALECENSA

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

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 INJ 1000MG/20ML

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 80% PREDICTED.
Age Restrictions	PATIENTS 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
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.

ALUNBRIG

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES A TRIAL OF CRIZOTINIB.

APTIOM

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.

ARCALYST

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.

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

AUBAGIO

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	1 YEAR
Other Criteria	N/A

AUGTYRO

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

AUVELITY

Products Affected

- Auvelity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF BUPROPION AND ONE OTHER GENERIC FORMULARY ANTIDEPRESSANT

AVMAPKI FAKZYNJA

Products Affected

- Avmapki Fakzynja Co-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

AVONEX

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	COVERAGE REQUIRES TRIAL OF BETASERON

AYVAKIT

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	1 YEAR
Other Criteria	N/A

BALVERSA

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CARCINOMA (MUC) WITH SUSCEPTIBLE FGFR3 GENETIC ALTERATIONS REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

BANZEL

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	COVERAGE REQUIRES THE TRIAL OF DIVALPROEX OR VALPROIC ACID, AND LAMOTRIGINE

BENLYSTA

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

BESREMI

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	COVERAGE REQUIRES TRIAL OF HYDROXYUREA AND PEGINTERFERON ALPHA-2A

BETASERON

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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ACCELERATED, OR BLAST PHASE PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY.

BRAFTOVI

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	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB. COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER (CRC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH CETUXIMAB AND mFOLFOX6. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB.

BRIVIACT

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 TRIAL OF LEVETIRACETAM AND ONE OTHER FORMULARY GENERIC ANTICONVULSANT

BRONCHITOL

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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF AT LEAST ONE PRIOR THERAPY. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY MARGINAL ZONE LYMPHOMA (MZL) REQUIRES A TRIAL OF AT LEAST ONE ANTI-CD20-BASED REGIMEN. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA (FL) REQUIRES COMBINATION USE WITH OBINUTUZUMAB AND A TRIAL OF TWO OR MORE LINES OF SYSTEMIC THERAPY.

CABLIVI

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP) REQUIRES COMBINATION USE WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY.

CABOMETYX

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	One Year
Other Criteria	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA REQUIRES COMBINATION USE WITH NIVOLUMAB. COVERAGE FOR THE TREATMENT OF HEPATOCELLULAR CARCINOMA (HCC) REQUIRES A TRIAL OF SORAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC DIFFERENTIATED THYROID CANCER (DTC) THAT IS RADIOACTIVE IODINE-REFRACTORY OR INELIGIBLE REQUIRES A TRIAL OF VEGFR-TARGETED THERAPY.

CALCIPOTRIENE

Products Affected

- Calcipotriene CREA
- 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.

CALQUENCE

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	ONE YEAR
Other Criteria	COVERAGE FOR MANTLE CELL LYMPHOMA (MCL) REQUIRES THAT THE PATIENT HAS RECEIVED AT LEAST ONE PRIOR THERAPY FOR THE TREATMENT OF MCL. COVERAGE FOR PREVIOUSLY UNTREATED MCL IN PATIENTS WHO ARE INELIGIBLE FOR AUTOLOGOUS HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) REQUIRES COMBINATION USE WITH BENDAMUSTINE AND RITUXIMAB.

CAPRELSA

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

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

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

CIALIS

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 THIE DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	N/A

CLOMIPHENE

Products Affected

- Clomid
- Clomiphene Citrate TABS
- Milophene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

COBENFY

Products Affected

- Cobenfy
- Cobenfy 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	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF AT LEAST TWO SECOND GENERATION ANTIPSYCHOTICS.

COMETRIQ

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

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

COPIKTRA

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL) REQUIRES A TRIAL OF AT LEAST TWO PRIOR THERAPIES.

COSENTYX

Products Affected

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

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	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 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.

COTELLIC

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	COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH VEMURAFENIB.

CYSTARAN

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

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	EXCLUDED FOR USE IF PATIENT IS WHEEL-CHAIR BOUND OR BECOMES WHEEL-CHAIR BOUND
Required Medical Information	SUBMISSION OF TIMED 25-FOOT WALK TEST
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF MULTIPLE SCLEROSIS (MS) REQUIRES DOCUMENTATION OF A BASELINE TIMED 25-FOOT WALK (T25FW) TEST PRIOR TO INITIATION. REAUTHORIZATION REQUIRES DOCUMENTATION OF STABILITY ON T25FW TEST OR IMPROVEMENT ON T25FW TEST

DALIRESP

Products Affected

- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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	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.

DAURISMO

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) REQUIRES COMBINATION USE WITH LOW-DOSE CYTARABINE.

DIACOMIT

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. COVERAGE FOR THE TREATMENT OF SEIZURES ASSOCIATED WITH DRAVET SYNDROME REQUIRES COMBINATION USE WITH CLOBAZAM.

DIHYDROERGOTAMINE NASAL SPRAY

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).

DRIZALMA SPRINKLE

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

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.

DUPIXENT

Products Affected

- Dupixent

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 18 YEARS OF AGE. CRSWNP, CSU: AT LEAST 12 YEARS OF AGE.
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ATOPIC DERMATITIS (AD) FOR PATIENTS 2 YEARS OF AGE AND OLDER REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR 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 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 RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP 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. COVERAGE FOR ADD-ON MAINTENANCE TREATMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) REQUIRES A DIAGNOSIS OF UNCONTROLLED, MODERATE TO SEVERE COPD AND AN EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 300 CELLS PER MICROLITER. COVERAGE FOR COPD ALSO REQUIRES THAT THE PATIENT IS CURRENTLY RECEIVING AND WILL CONTINUE TO RECEIVE THE FOLLOWING, UNLESS CONTRAINDICATED: A LONG-ACTING BETA-2 AGONST (LABA, E.G. SALMETEROL), A LONG-ACTING MUSCARINIC ANTAGONIST (LAMA, E.G., TIOTROPIUM), AND AN INHALED CORTICOSTEROID (E.G., FLUTICASONE).
Other Criteria	COVERAGE FOR CHRONIC SPONTANEOUS URTICARIA (CSU) REQUIRES DIAGNOSIS OF CSU AND SYMPTOMS DESPITE H1 ANTIHISTAMINE TREATMENT. COVERAGE FOR CSU ALSO REQUIRES 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 ANTIHISTAMINE, HYDROXYZINE, OR DOXEPIN. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

EMGALITY

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	N/A

EMSAM

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	COVERAGE REQUIRES TRIAL WITH TWO OF THE FOLLOWING: MARPLAN, PHENELZINE, TRANYLCYPROMINE

ENBREL

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

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	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 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.

ENDARI

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.

ENHERTU

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	COVERAGE FOR HER2-POSITIVE (IHC 3+ OR ISH+) BREAST CANCER REQUIRES PRIOR ANTI-HER2 BASED TREATMENT EITHER IN THE NEOADJUVANT/ADJUVANT SETTING WITH DISEASE RECURRENCE DURING OR WITHIN 6 MONTHS OF COMPLETING THERAPY OR IN THE METASTATIC SETTING. COVERAGE FOR HORMONE RECEPTOR (HR)-POSITIVE, HER2-LOW (IHC 1+ OR IHC 2+/ISH-) OR HER2-ULTRALOW (IHC 0 WITH MEMBRANE STAINING) BREAST CANCER REQUIRES PROGRESSION ON ONE OR MORE ENDOCRINE THERAPIES IN THE METASTATIC SETTING. COVERAGE FOR HER2-LOW (IHC 1+ OR IHC 2+/ISH-) BREAST CANCER REQUIRES PRIOR CHEMOTHERAPY IN THE METASTATIC SETTING OR DISEASE RECURRENCE DURING OR WITHIN 6 MONTHS OF COMPLETING ADJUVANT CHEMOTHERAPY. COVERAGE FOR NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE ACTIVATING HER2 (ERBB2) MUTATIONS REQUIRES PRIOR SYSTEMIC THERAPY. COVERAGE FOR HER2-POSITIVE (IHC 3+ OR IHC 2+/ISH+) GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA REQUIRES PRIOR TRASTUZUMAB-BASED TREATMENT. COVERAGE FOR HER2-POSITIVE (IHC 3+) SOLID TUMORS REQUIRES PRIOR SYSTEMIC TREATMENT.

ENSACOVE

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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.

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.

EPRONTIA

Products Affected

- Eprontia
- Topiramate 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 FOR THE PREVENTATIVE TREATMENT OF MIGRAINE REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ALTERNATIVES FOR MIGRAINE PREVENTION, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES. COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER/EPILEPSY REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC TOPIRAMATE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES

ERIVEDGE

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

ERLEADA

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

Products Affected

- 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.

ESBRIET

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

EULEXIN

Products Affected

- Eulexin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 BICALUTAMIDE.

EXKIVITY

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	One Year
Other Criteria	COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATIONS WITH DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY.

FANAPT

Products Affected

- Fanapt
- Fanapt Titration Pack A
- Fanapt Titration Pack B
- Fanapt Titration Pack C

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF TWO GENERIC FORMULARY ATYPICAL ANTIPSYCHOTICS (E.G., ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE)

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

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	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	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 EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA AND HISTORY OR PRESENCE OF ASTHMA. FOR ALL INDICATIONS, REAUTHORIZATION

	REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

FETZIMA

Products Affected

- Fetzima
- Fetzima 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	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF VENLAFAXINE (OR DESVENLAFAXINE) AND DULOXETINE

FINTEPLA

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.

FIRAZYR

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

FOTIVDA

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	One Year
Other Criteria	COVERAGE FOR ADVANCED RENAL CELL CARCINOMA REQUIRES A TRIAL OF TWO OR MORE PRIOR SYSTEMIC THERAPIES.

FRUZAQLA

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	COVERAGE FOR METASTATIC COLORECTAL CANCER (mCRC) REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METASTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY

FYCOMPA

Products Affected

- Fycompa
- Perampanel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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.

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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

GAVRETO

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	COVERAGE FOR ADVANCED OR METASTATIC RET FUSION-POSITIVE THYROID CANCER THAT REQUIRES SYSTEMIC THERAPY AND RADIOACTIVE IODINE-REFRACTORY (IF RADIOACTIVE IODINE IS APPROPRIATE).

GILENYA

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

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	One Year
Other Criteria	COVERAGE WILL BE PROVIDED AS FIRST-LINE TREATMENT OF PATIENTS WITH METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE NON-RESISTANT EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST, AND FOR PATIENTS WITH METASTATIC NSCLC PROGRESSING AFTER PLATINUM-BASED CHEMOTHERAPY.

GLP-1 AGONISTS

Products Affected

- Liraglutide INJ 6MG/ML
- 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

GOMEKLI

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

HAEGARDA

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

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.

HERNEXEOS

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter
- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

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	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 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. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. 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.

HUMULIN R U-500

Products Affected

- Humulin R U-500 (concentrated)
- Humulin R U-500 Kwikpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT IN PATIENTS WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY. COVERAGE FOR THE TREATMENT OF ENDOCRINE-RESISTANT, PIK3CA-MUTATED, HR-POSITIVE, HER2-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH INAVOLISIB AND FULVESTRANT FOLLOWING RECURRENCE ON OR AFTER COMPLETING ADJUVANT ENDOCRINE THERAPY.

IBTROZI

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED PHILADELPHIA CHROMOSOME-POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ ALL) REQUIRES COMBINATION USE WITH CHEMOTHERAPY. COVERAGE FOR THE TREATMENT OF CHRONIC PHASE (CP) CHRONIC MYELOID LEUKEMIA (CML) REQUIRES THE TRIAL AT LEAST TWO PRIOR KINASE INHIBITORS.

IDHIFA

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

Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 420MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 FOR TREATMENT OF CHRONIC GRAFT VERSUS HOST DISEASE REQUIRE A TRIAL OF ONE OR MORE LINES OF SYSTEMIC THERAPY.

IMKELDI

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 ALL INDICATIONS REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION OR IS UNABLE TO ACHIEVE PRESCRIBED DOSE WITH TABLET FORMULATION. COVERAGE FOR A DIAGNOSIS OF PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA (PH+ CML) IN BLAST CRISIS (BC), ACCELERATED PHASE (AP), OR IN CHRONIC PHASE (CP) REQUIRES FAILURE OF INTERFERON-ALPHA THERAPY.

IMMUNE GLOBULIN (IVIG) PRODUCTS

Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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	IMMUNE GLOBULIN (IVIG) PRODUCTS ARE SUBJECT TO PART B VS PART D REVIEW.

INCRELEX

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

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	One Year
Other Criteria	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRE COMBINATION USE WITH AVELUMAB OR PEMBROLIZUMAB. COVERAGE FOR TREATMENT OF ADVANCED CELL CARCINOMA (RCC) REQUIRES A TRIAL OF ONE PRIOR SYSTEMIC THERAPY.

INQOVI

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	1 YEAR
Other Criteria	COVERAGE REQUIRES TRIAL WITH AZACITIDINE

INREBIC

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

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

Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- 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.

ITOVEBI

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 ENDOCRINE-RESISTANT, PIK3CA-MUTATED, HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH PALBOCICLIB AND FULVESTRANT.

IVERMECTIN

Products Affected

- Ivermectin TABS 3MG

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

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	COVERAGE FOR THE TREATMENT OF HIGH-RISK NEUROBLASTOMA (HRNB) WHO HAVE DEMONSTRATED AT LEAST A PARTIAL RESPONSE TO PRIOR MULITAGENT, MULTIMODALITY THERAPY INCLUDING ANTI-GD2 IMMUNOTHERAPY.

JADENU

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

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	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF POLYCYTHEMIA VERA THAT DEMONSTRATED AN INADEQUATE RESPONSE OR ARE INTOLERANT TO HYDROXYUREA. COVERAGE FOR THE TREATMENT OF CHRONIC VERSUS HOST DISEASE REQUIRES A TRIAL OF ONE OR TWO LINES OF SYSTEMIC THERAPY.

JAYPIRCA

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	COVERAGE FOR MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF TWO LINES OF SYSTEMIC THERAPY (INCLUDING A BTK INHIBITOR). COVERAGE FOR CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LYMPHOMA (CLL/SLL) REQUIRES A TRIAL OF TWO PRIOR LINES OF SYSTEMIC THERAPY (INCLUDING A BTK INHIBITOR AND A BCL-2 INHIBITOR).

JOENJA

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 PI3Kδ 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

JYLAMVO

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 METHOTREXATE TABLET, OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL TABLET FORMULATION OF METHOTREXATE

KALYDECO

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

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

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

Products Affected

- Kevzara

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	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, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, 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, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, XELJANZ/XR, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

KINERET

Products Affected

- Kineret

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	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, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, RINVOQ, XELJANZ/XR, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

KISQALI

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	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT AS INITIAL ENDOCRINE BASED THERAPY OR FOLLOWING DISEASE PROGRESSION ON ENDOCRINE THERAPY. COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE STAGE II AND III EARLY BREAST CANCER AT HIGH RISK OF RECURRENCE REQUIRES COMBINATION USE WITH AN AROMATASE INHIBITOR.

KORLYM

Products Affected

- 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

Products Affected

- Koselugo 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

KRAZATI

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	COVERAGE FOR THE TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.

LAZCLUZE

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

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 FOR RENAL CELL CARCINOMA (RCC) AS FIRST LINE THERAPY REQUIRES COMBINATION USE WITH PEMBROLIZUMAB. COVERAGE FOR RENAL CELL CARCINOMA (RCC) REQUIRES COMBINATION USE WITH EVEROLIMUS FOLLOWING ONE PRIOR ANTI-ANGIOGENIC THERAPY. COVERAGE FOR ADVANCED ENDOMETRIAL CARCINOMA (EC) REQUIRES COMBINATION USE WITH PEMBROLIZUMAB WHO HAVE DISEASE PROGRESSION FOLLOWING PRIOR SYSTEMIC THERAPY.

LEUPROLIDE

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)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

LIBERVANT

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

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	COVERAGE FOR BASAL CELL CARCINOMA (BCC) REQUIRES EITHER PRIOR TREATMENT WITH A HEDGEHOG PATHWAY INHIBITOR OR INELIGIBILITY FOR HEDGEHOG PATHWAY INHIBITOR TREATMENT.

LIDOCAINE TOPICALS

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

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	COVERAGE FOR THE TREATMENT OF POST-TRANSPLANT CMV INFECTION/DISEASE REQUIRES A TRIAL OF ONE OF THE FOLLOWING TREATMENTS: GANCICLOVIR, VALGANCICLOVIR, CIDOFOVIR, OR FOSCARNET.

LONSURF

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	COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METATSTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY. COVERAGE FOR THE METASTATIC GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA REQUIRES A TRIAL OF AT LEAST TWO PRIOR LINES OF CHEMOTHERAPY THAT INCLUDES FLUOROPYRIMIDINE, PLATINUM BASED, TAXANE OR IRINOTECAN-BASED CHEMOTHERAPY OR IF APPROPRIATE, AN HER2/NEU-TARGETED THERAPY.

LORBRENA

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

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	ONE YEAR
Other Criteria	COVERAGE FOR TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY. COVERAGE FOR KRAS G12C-MUTATED METASTATIC COLORECTAL CANCER (mCRC) IN PATIENTS WHO HAVE RECEIVED PRIOR FLUOROPYRIMIDINE-, OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY REQUIRES COMBINATION USE WITH PANITUMUMAB.

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 AT LEAST ONE OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, FLUPHENAZINE, HALOPERIDOL, LOXAPINE, LURASIDONE, MOLINDONE, PALIPERIDONE, PIMOZIDE, QUETIAPINE, RISPERIDONE, THIORIDAZINE, THIOTHIXENE, TRIFLUOPERAZINE, ZIPRASIDONE.

LYNPARZA

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	One Year
Other Criteria	COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm, HER2-NEGATIVE METASTATIC BREAST CANCER REQUIRE PRIOR CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER REQUIRES PREVIOUS ENDOCRINE THERAPY OR CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm METASTATIC PANCREATIC ADENOCARCINOMA REQUIRES A TRIAL OF WHOSE DISEASE HAS NOT PROGRESSED ON AT

	LEAST 16 WEEKS OF FIRST-LINE PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC HOMOLOGUS RECOMBINATION REPAIR (HRR) GENE-MUTATED CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES A TRIAL OF ENZALUTAMIDE OR ABIRATERONE. COVERAGE FOR TREATMENT OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES COMBINATION USE WITH ABIRATERONE AND PREDNISONE OR PREDNISOLONE.

LYTGOBI

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

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	COVERAGE FOR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES PRIOR TREATMENT WITH TWO OR MORE ANTI-HER2 REGIMENS, AT LEAST ONE OF WHICH WAS FOR METASTATIC DISEASE.

MEKINIST

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	COVERAGE IS PROVIDED AS MONOTHERAPY FOR BRAF-INHIBITOR TREATEMENT-NAIVE PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR V600K MUTATIONS AS DETECTED BY AN FDA APPROVED TEST. REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC SOLID TUMORS WITH BRAF V600E MUTATION WHO FAILED PRIOR TREATMENT REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR THE TREATMENT OF LOW-GRADE GLIOMA (LGG) WITH A BRAF V600E MUTATION WHO REQUIRE SYSTEMIC THERAPY AND COMBINATION USE WITH DABRAFENIB.

MEKINIST LIQUID FORMULATION

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. COVERAGE IS PROVIDED AS MONOTHERAPY FOR BRAF-INHIBITOR TREATEMENT-NAIVE PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR V600K MUTATIONS AS DETECTED BY AN FDA APPROVED TEST. REQUIRES TRIAL WITH ZELBORAF AND COTELLIC USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC SOLID TUMORS WITH BRAF V600E MUTATION WHO FAILED PRIOR TREATMENT REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR THE

	TREATMENT OF LOW-GRADE GLIOMA (LGG) WITH A BRAF V600E MUTATION WHO REQUIRE SYSTEMIC THERAPY AND COMBINATION USE WITH DABRAFENIB.

MEKTOVI

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	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA REQUIRES COMBINATION USE WITH ENCORAFENIB. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH ENCORAFENIB.

MEMANTINE

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.

MIGLUSTAT

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

MODEYSO

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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

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.

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.

NARCOLEPSY AGENTS

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

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

NAYZILAM

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

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	One Year
Other Criteria	COVERAGE FOR ADVANCED OR METASTATIC HER2-POSITIVE BREAST CANCER IN COMBINATION WITH CAPECITABINE REQURIES TREATMENT WITH TWO OR MORE PRIOR ANTI-HER2 BASED REGIMENS.

NEULASTA

Products Affected

- Neulasta
- Neulasta Onpro 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	N/A

NEXAVAR

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	One Year
Other Criteria	COVERAGE FOR LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, DIFFERENTIATED THYROID CARCINOMA (DTC) REQUIRES TRIAL AND FAILURE OF RADIOACTIVE IODINE TREATMENT.

NINLARO

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	COVERAGE FOR TREATMENT OF PATIENTS WITH MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST ONE PRIOR THERAPY AND USE IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE.

NORTHERA

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.

NUBEQA

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

Products Affected

- Nucala

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	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	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 EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA. 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 STABILITY ON HES THERAPY (SUCH AS ORAL CORTICOSTEROIDS, IMMUNOSUPPRESSIVE, OR CYTOTOXIC THERAPY). COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). COVERAGE FOR ADD-ON MAINTENANCE TREATMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) REQUIRES A DIAGNOSIS OF UNCONTROLLED, MODERATE TO SEVERE COPD AND EITHER 1) A CURRENT EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 150 CELLS PER MICROLITER, OR 2) AN EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 300 CELLS PER MICROLITER WITHIN THE PAST 12 MONTHS . COVERAGE FOR COPD ALSO REQUIRES THAT THE PATIENT IS CURRENTLY RECEIVING AND WILL CONTINUE TO RECEIVE THE FOLLOWING, UNLESS CONTRAINDICATED: A LONG-ACTING BETA-2 AGONST (LABA, E.G. SALMETEROL), A LONG-ACTING MUSCARINIC ANTAGONIST (LAMA, E.G., TIOTROPIUM), AND AN INHALED CORTICOSTEROID (E.G., FLUTICASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

NUEDEXTA

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

NUPLAZID

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

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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, UNLESS TRIPTAN THERAPY IS CONTRAINDICATED, NOT TOLERATED, OR CLINICALLY INAPPROPRIATE DUE TO OTHER CONCURRENT HEALTH CONDITIONS.

OCTREOTIDE ACETATE

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	One Year
Other Criteria	COVERAGE FOR ACROMEGALY REQUIRES TRIAL OF BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES.

ODOMZO

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

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

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

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

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.

OJJAARA

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

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	COVERAGE IS PROVIDED FOR ADULT PATIENTS WITH ACUTE MYELOID LEUKEMIA WHO ACHIEVED FIRST COMPETE REMISSION (CR) OR COMPLETE REMISSION WITH INCOMPLETE BLOOD COUNT RECOVERY (CRi) FOLLOWING INTENSIVE INDUCTION CHEMOTHERAPY AND ARE NOT ABLE TO COMPLETE INTENSIVE CURATIVE THERAPY.

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). COVERAGE REQUIRES NO IMPROVEMENT ON CURRENT ENZYME REPLACEMENT THERAPY (ERT).

OPIPZA

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 PATIENT IS UNABLE TO USE ORAL TABLET OR ORAL DISINTEGRATING TABLET FORMULATIONS.

ORENCIA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS)
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 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).

ORFADIN

Products Affected

- Nitisinone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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.

ORKAMBI

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

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	COVERAGE FOR THE TREATMENT OF ER-POSITIVE, HER2-NEGATIVE, ESR1-MUTATED ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR TREATMENT WITH AT LEAST ONE LINE OF ENDOCRINE THERAPY

OTEZLA

Products Affected

- Otezla

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	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.

PADCEV

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	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER REQUIRES PRIOR TREATMENT WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND PLATINUUM-CONTAINING CHEMOTHERAPY OR ARE INELIGIBLE FOR CISPLATING-CONTAINING CHEMOTHERAPY AND HAVE PREVIOUSLY RECEIVED ONE OR MORE PRIOR LINES OF THERAPY.

PANRETIN

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

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	1 YEAR
Other Criteria	N/A

PHENOBARBITAL

Products Affected

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

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

PIQRAY

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	COVERAGE FOR TREATMENT OF ADULTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, PIK3CA-MUTATED, ADVANCED OR METASTATIC BREAST CANCER REQUIRES PROGRESSION ON OR AFTER AN ENDOCRINE-BASED REGIMEN AND COMBINATION THERAPY WITH FULVESTRANT.

POLIVY

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	COVERAGE FOR RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED (NOS) REQUIRES TRIAL OF AT LEAST TWO PRIOR THERAPIES.

POMALYST

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	COVERAGE FOR MULTIPLE MYELOMA REQUIRES 1) AT LEAST TWO PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR, IN PATIENTS WHO HAVE DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF THE LAST THERAPY, AND 2)COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR AIDS-RELATED KAPOSI SARCOMA (KS) REQUIRES TRIAL AND FAILURE OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART).

POSACONAZOLE DR

Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	COVERAGE FOR PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS (IFI): USED AS PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS CAUSED BY ASPERGILLUS OR CANDIDA FOR ONE OF THE FOLLOWING CONDITIONS: 1) PATIENT IS AT HIGH RISK OF INFECTIONS DUE TO SEVERE IMMUNOSUPPRESSION FROM HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) WITH GRAFT-VERSUS-HOST DISEASE (GVHD) OR HEMATOLOGIC MALIGNANCIES WITH PROLONGED NEUTROPENIA FROM CHEMOTHERAPY [E.G., ACUTE MYELOID LEUKEMIA (AML), MYELODYSPLASTIC SYNDROME (MDS)], OR 2) PATIENT HAS A PRIOR FUNGAL INFECTION REQUIRING SECONDARY PROPHYLAXIS. COVERAGE FOR PROPHYLAXIS ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE. COVERAGE FOR TREATMENT OF IFI: USED AS TREATMENT OF INVASIVE FUNGAL INFECTIONS CAUSED BY ASPERGILLUS AND CANDIDA. COVERAGE FOR TREATMENT ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE.

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review

PREVYMIS

Products Affected

- Prevymis PACK
- Prevymis 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 FOR CYTOMEGALOVIRUS (CMV) PROPHYLAXIS, IN CMV-SEROPOSITIVE RECIPIENT [R+] OF AN ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT), OR, IN KIDNEY TRANSPLANT RECIPIENTS AT HIGH RISK [DONOR IS CMV SEROPOSITIVE/RECIPIENT IS CMV SERONEGATIVE: D+/R-]

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.

PROMACTA

Products Affected

- Eltrombopag Olamine TABS
- 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

PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

Products Affected

- Ambrisentan
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE IS NOT PROVIDED FOR SILDENAFIL 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

QINLOCK

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	COVERAGE FOR ADULT PATIENTS WITH ADVANCED GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PRIOR THERAPY WITH 3 OR MORE KINASE INHIBITORS, INCLUDING IMATINIB.

QUININE

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

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	N/A

RALDESY

Products Affected

- Raldesy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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.

RECORLEV

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.

REPATHA

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	ASCVD (INIT): CONFIRMATION THAT PT IS AT INCREASED RISK FOR ONE OF THE FOLLOWING CV EVENTS: CV DEATH, MI, STROKE, UNSTABLE ANGINA REQUIRING HOSPITALIZATION, OR CORONARY REVASCULARIZATION. PRIMARY HLD (INIT): DIAGNOSIS OF PRIMARY HYPERLIPIDEMIA (HLD). HeFH (INIT): HeFH AS CONF BY ONE OF THE FOLLOWING: (1) BOTH OF THE FOLLOWING: A) UNTREATED/PRE-TREATMENT LDL GREATER THAN 190 MG/DL REQUIRED FOR ADULTS ONLY, AND B) ONE OF THE FOLLOWING: 1) FAMILY HX OF TENDINOUS XANTHOMA(S) IN 1ST/2ND DEG RELATIVES AND/OR ARCUS CORNEALIS IN 1ST DEG RELATIVE, 2) HX OF MI IN 1ST DEG RELATIVE UNDER 60 YRS/1ST DEG RELATIVE WITH KNOWN PREMATURE CORONARY AND VASCULAR DISEASE (UNDER 55 YRS IN MEN, UNDER 60 YRS IN WOMEN), 3) FAMILY HX OF MI IN 2ND DEG RELATIVE LESS THAN 50 YRS OF AGE, 4) FAMILY HX OF LDL-C GREATER THAN 290 MG/DL IN 1ST/2ND DEG RELATIVE, 5) FAMILY HX OF FH IN 1ST/2ND DEG RELATIVE, OR (2) UNTREATED/PRE-TREATMENT LDL-C GREATER THAN 190 MG/DL REQUIRED FOR ADULTS ONLY AND ONE OF THE FOLLOWING: PRESENCE OF TENDINOUS XANTHOMA IN PT, ARCUS CORNEALIS BEFORE AGE 45, OR FUNCTIONAL MUTATION IN THE LDL RECEPTOR, APOB, OR PCSK9 GENE. ASCVD/PRIMARY HLD/HeFH (INIT), ONE OF THE FOLLOWING: LDL VALUES WHILE ON A HIGH INTENSITY STATIN (ATORVASTATIN 40-80MG OR ROSUVASTATIN 20-40MG) W/IN THE LAST 120 DAYS: (1) LDL OVER/EQUAL TO 70 MG/DL W/ASCVD, OR (2) LDL OVER 100 MG/DL W/O ASCVD. ONE OF THE FOLLOWING: (1) PT HAS BEEN RECEIVING AT LEAST 12 WKS OF HIGH INTENSITY STATIN AND WILL CONTINUE TO RECEIVE A STATIN AT MAX TOLERATED DOSE, (2) PT IS UNABLE TO TOLERATE STATIN (E.G., MYALGIA, MYOSITIS, RHABDOMYOLYSIS) AND HAS TRIED ATORVASTATIN AND ROSUVASTATIN. HoFH (INIT): DX OF HOFH AS CONF BY ONE OF THE FOLLOWING: (1) GEN CONF OF 2 MUTATIONS IN LDL RECEPTOR, APOB, PCSK9, LDLRAP1 OR ARH, OR (2) EITHER

	UNTREATED LDL OVER 500 OR TREATED LDL OVER 300, AND EITHER XANTHOMA BEFORE 10 YO OR EVIDENCE OF HEFH IN BOTH PARENTS. PT IS RECEIVING OTHER LIPID-LOWERING TX. NOT USED IN COMBO WITH JUXTAPID
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	HeFH/ASCVD/PRIMARY HLD (REAUTH): PT CONTINUES TO RECEIVE STATIN AT MAX TOLERATED DOSE (UNLESS PT HAS DOCUMENTED INABILITY TO TAKE STATINS). PT HAS EXPERIENCED LDL REDUCTION WHILE ON REPATHA TX. HoFH (REAUTH): PT CONTINUES TO RECEIVE OTHER LIPID-LOWERING TX (EG STATIN, EZETIMIBE). NOT USED IN COMBO W/ JUXTAPID. PT HAS EXPERIENCED LDL REDUCTION WHILE ON REPATHA TX.

RETEVMO

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	COVERAGE IS PROVIDED FOR ADULT PATIENTS WITH LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A REARRANGED DURING TRANSFECTION (RET) GENE FUSION, AS DETECTED BY AN FDA-APPROVED TEST. COVERAGE IS PROVIDED FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH ADVANCED OR METASTATIC MEDULLARY THYROID CANCER (MTC) WITH A RET MUTATION AS DETECTED BY AN FDA-APPROVED TEST, WHO REQUIRE SYSTEMIC THERAPY. COVERAGE FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH ADVANCED OR METASTATIC THYROID CANCER WITH A RET-GENE FUSION AS DETECTED BY AN FDA-APPROVED TEST REQUIRES TRIAL AND FAILURE WITH RADIOACTIVE IODINE (IF RADIOACTIVE IODINE IS APPROPRIATE). COVERAGE FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH LOCALLY ADVANCED OR METASTATIC SOLID TUMORS WITH A RET-GENE FUSION IS PROVIDED FOR THOSE PATIENTS WHO HAVE PROGRESSED ON OR FOLLOWING PRIOR SYSTEMIC TREATMENT.

REVLIMID

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	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 or in consultation with an oncologist or hematologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA REQUIRES COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR MANTLE CELL LYMPHOMA REQUIRES DISEASE RELAPSE OR PROGRESSION AFTER TWO PRIOR THERAPIES, ONE OF WHICH INCLUDES BORTEZOMIB. COVERAGE FOR PREVIOUS TREATED FOLLICULAR LYMPHOMA OR PREVIOUSLY TREATED MARGINAL ZONE LYMPHOMA REQUIRES COMBINATION USE WITH A RITUXIMAB PRODUCT.

REVUFORJ

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

REZLIDHIA

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

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	COVERAGE FOR THE TREATMENT OF ADULT AND PEDIATRIC PATIENTS 12 YEARS AND OLDER WITH CHRONIC GRAFT-VERSUS-HOST DISEASE (CHRONIC GVHD) REQUIRES TRIAL AND FAILURE OF AT LEAST TWO PRIOR LINES OF SYSTEMIC THERAPY.

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
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 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. COVERAGE FOR NONRADIOGRAPHIC 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 CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. 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, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM) 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 AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR MYCOPHENOLATE MOFETIL. COVERAGE FOR GIANT CELL ARTERITIS (GCA) REQUIRES A DIAGNOSIS OF GCA. 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).

RINVOQ LIQUID FORMULATION

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
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 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).

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

ROMVIMZA

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

ROZLYTREK

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	1 YEAR
Other Criteria	N/A

RUBRACA

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	One Year
Other Criteria	COVERAGE IS PROVIDED FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN COMPLETE OR PARTIAL RESPONSE TO PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES PREVIOUS THERAPY WITH ANDROGEN RECEPTOR-DIRECTED THERAPY AND A TAXANE-BASED CHEMOTHERAPY.

RYBREVANT

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	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATIONS REQUIRES DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF ADULT PATIENTS WITH LOCALLY ADVANCED OR METASTATIC NSCLC WITH EGFR EXON 19 DELETIONS OR EXON 21 L858R SUBSTITUTION MUTATIONS WHOSE DISEASE HAS PROGRESSED ON OR AFTER TREATMENT WITH AN EGFR TYROSINE KINASE INHIBITOR REQUIRES COMBINATION USE WITH CARBOPLATIN AND PEMETREXED.

RYDAPT

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	One Year
Other Criteria	COVERAGE FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 MUTATION-POSITIVE REQUIRES COMBINATION THERAPY WITH STANDARD CYTARABINE AND DAUNORUBICIN INDUCTION AND CYTARABINE CONSOLIDATION.

RYLAZE

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

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.

SARCLISA

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	COVERAGE FOR MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST 2 PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR. COVERAGE FOR RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TREATMENT WITH 1 TO 3 PRIOR LINES OF THERAPY. COVERAGE FOR ADULT PATIENTS WITH NEWLY DIAGNOSED MULTIPLE MYELOMA WHO ARE NOT ELIGIBLE FOR AUTOLOGOUS STEM CELL TRANSPLANT (ASCT) REQUIRES COMBINATION USE WITH BORTEZOMIB, LENALIDOMIDE AND DEXAMETHASONE.

SAVELLA

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.

SCEMBLIX

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

SECUADO

Products Affected

- Secuado

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF ASENAPINE TABLET (SUBLINGUAL), OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL OR ORALLY DISINTEGRATING TABLET (ODT) FORMULATIONS

SIGNIFOR

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

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.

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML
- Skyrizi Pen

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	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.

SKYRIZI 360 MG

Products Affected

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

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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

SOHONOS

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

SOMATULINE DEPOT

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

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

SPRITAM

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.

SPRYCEL

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. COVERAGE FOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) REQUIRES ONE OF THE FOLLOWING: 1) SPRYCEL TO BE USED IN COMBINATION WITH CHEMOTHERAPY IN NEWLY DIAGNOSED ALL OR 2) RESISTANCE OR INTOLERANCE TO PRIOR THERAPY.

STELARA

Products Affected

- Wezlana INJ 45MG/0.5ML, 90MG/ML
- Yesintek INJ 45MG/0.5ML, 90MG/ML

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	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. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

STIVARGA

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	One Year
Other Criteria	COVERAGE FOR COLORECTAL CANCER (CRC) REQUIRES PREVIOUS TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY, AN ANTI-VEGF THERAPY, AND, IF RAS WILD-TYPE, AN ANTI-EGFR THERAPY. COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PREVIOUS TREATMENT WITH IMATINIB MESYLATE AND SUNITINIB MALATE. COVERAGE FOR HEPATOCELLULAR CARCINOMA (HCC) REQUIRES PREVIOUS TREATMENT WITH SORAFENIB.

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 ARMODAFINIL

SUTENT

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	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES DISEASE PROGRESSION ON OR INTOLERANCE TO IMATINIB MESYLATE

SYMPAZAN

Products Affected

- Clobazam SUSP 2.5MG/ML
- Clobazam TABS
- 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

TABLOID

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	1 YEAR
Other Criteria	N/A

TABRECTA

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	1 YEAR
Other Criteria	N/A

TAFINLAR

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	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG).

TAFINLAR LIQUID FORMULATION

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 FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG). COVERAGE FOR ALL CONDITIONS REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW CAPSULE FORMULATION.

TAGRISSO

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	COVERAGE FOR EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETION- OR EXON 21 L858R MUTATION-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES TAGRISSO TO BE USED 1) AS ADJUVANT THERAPY AFTER TUMOR RESECTION, 2) AS FIRST-LINE TREATMENT IN METASTATIC DISEASE, OR 3) AS FIRST-LINE TREATMENT IN LOCALLY ADVANCED OR METASTATIC DISEASE IN COMBINATION WITH PEMETREXED AND PLANTIUM-BASED CHEMOTHERAPY. COVERAGE FOR EGFR T790M MUTATION-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES DISEASE PROGRESSION ON OR AFTER EGFR TYROSINE KINASE INHIBITOR (TKI) THERAPY. COVERAGE IS ALSO PROVIDED FOR TREATMENT OF ADULT PATIENTS WITH LOCALLY ADVANCED, UNRESECTABLE (STAGE III) NSCLC WITH EGFR EXON 19 DELETIONS OR EXON 21 L8F8R MUTATIONS WHOSE DISEASE HAS NOT PROGRESSED DURING OR FOLLOWING CONCURRENT OR SEQUENTIAL PLATINUM-BASED CHEMORADIATION THERAPY.

TALZENNA

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	One Year
Other Criteria	COVERAGE FOR METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES TALZENNA TO BE USED IN COMBINATION WITH ENZALUTAMIDE

TARCEVA

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	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES CONCURRENT TREATMENT WITH FIRST-LINE, MAINTENANCE, OR SECOND OR GREATER LINE TREATMENT AFTER PROGRESSION FOLLOWING AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN. COVERAGE FOR PANCREATIC CANCER REQUIRES THAT ERLOTINIB IS USED IN COMBINATION WITH GEMCITABINE.

TARGRETIN

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	Prescribed by a dermatologist or oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR BEXAROTENE CAPSULE FOR CUTANEOUS T-CELL LYMPHOMA REQUIRES THAT THIS CONDITION IS REFRACTORY TO AT LEAST ONE PRIOR SYSTEMIC THERAPY. COVERAGE FOR BEXAROTENE GEL FOR CUTANEOUS T-CELL LYMPHOMA REQUIRES THAT THIS CONDITION IS REFRACTORY TO, PERSISTENT AFTER, OR INTOLERANT OF OTHER THERAPIES.

TASIGNA

Products Affected

- Nilotinib Hydrochloride
- Tasigna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 ADULT PATIENTS WITH CHRONIC PHASE (CP) CML NOT NEWLY DIAGNOSED AND ACCELERATED PHASE (AP) PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY THAT INCLUDED IMATINIB. COVERAGE FOR PEDIATRIC PATIENTS WITH PH+ CML-CP AND CML-AP REQUIRES A TRIAL OF A TYROSINE-KINASE INHIBITOR (TKI) THERAPY.

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

TAZAROTENE

Products Affected

- Tazarotene CREA 0.1%
- Tazarotene GEL 0.05%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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	One Year
Other Criteria	COVERAGE FOR EZH2 MUTATION-POSITIVE FOLLICULAR LYMPHOMA REQUIRES PRIOR TREATMENT WITH AT LEAST TWO SYSTEMIC THERAPIES

TECFIDERA

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

TEPMETKO

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

Products Affected

- Testosterone GEL 25MG/2.5GM
- Testosterone Pump

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

TETRABENAZINE

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

THALOMID

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	One Year
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA (MM) REQUIRES THALOMID TO BE USED IN COMBINATION WITH DEXAMETHASONE. COVERAGE FOR ACUTE TREATMENT OF ERYTHEMA NODOSUM LEPROSUM (ENL) WITH PRESENCE OF MODERATE TO SEVERE NEURITIS REQUIRES THALOMID TO BE PART OF A COMBINATION THERAPY.

TIBSOVO

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	One Year
Other Criteria	COVERAGE FOR CHOLANGIOCARCINOMA REQUIRES PREVIOUS TREATMENT

TIVDAK

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	COVERAGE FOR RECURRENT OR METASTATIC CERVICAL CANCER REQUIRES DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY.

TOBI PODHALER

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 TOBRAMYCIN INHALATION NEBULIZATION SOLUTION.

TOPICAL TRETINOIN

Products Affected

- Tretinoin CREA
- Tretinoin GEL 0.01%, 0.025%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

Products Affected

- Trelstar Mixject INJ 11.25MG, 3.75MG

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

TRIENTINE HCL

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	One Year
Other Criteria	COVERAGE FOR WILSON'S DISEASE WHO ARE INTOLERANT TO PENCILLAMINE.

TRIKAFTA

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

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	COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC TRIPLE-NEGATIVE BREAST CANCER (MTNBC) REQUIRES PRIOR USE OF TWO OR MORE SYSTEMIC THERAPIES, WITH AT LEAST ONE OF THEM FOR METASTATIC DISEASE. COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC HORMONE RECEPTOR POSITIVE (HR+), HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 NEGATIVE (HER2-) (IHC 0, IHC 1+ OR IHC 2+/ISH-) BREAST CANCER REQUIRES PRIOR USE OF ENDOCRINE-BASED THERAPY AND AT LEAST TWO ADDITIONAL SYSTEMIC THERAPIES IN THE METASTATIC SETTING.

TRUQAP

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	COVERAGE FOR HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER WITH ONE OR MORE PIK3CA/AKT1/PTEN-ALTERACTIONS REQUIRES PROGRESSION ON AT LEAST ONE ENDOCRINE BASED REGIMEN OR RECURRENCE ON OR WITHIN 12 MONTHS OF COMPLETING ADJUVANT THERAPY AND COMBINATION USE WITH FULVESTRANT

TUKYSA

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	COVERAGE FOR ADVANCED UNRESCETABLE OR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES A TRIAL OF ONE OR MORE PRIOR ANTI-HER2-BASED REGIMENS AND COMBINATION THERAPY WITH TRASTUZUMAB AND CAPECITABINE. COVERAGE FOR RAS WILD-TYPE HER2-POSITIVE UNRESECTABLE OR METASTATIC COLORECTAL CANCER REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY AND COMBINATION THERAPY WITH TRASTUZUMAB

TURALIO

Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

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	One Year
Other Criteria	COVERAGE FOR ADVANCED OR METASTATIC BREAST CANCER WHOSE TUMORS OVEREXPRESS HER2 RECEPTOR REQUIRES A TRIAL OF PRIOR THERAPY INCLUDING AN ARTHRACYCLINE, A TAXANE, AND TRASTUZUMAB AND COMBINATION USE WITH CAPECITABINE. COVERAGE FOR HORMONE RECEPTOR-POSITIVE METASTATIC BREAST CANCER THAT OVEREXPRESS HER2 RECEPTORS AND COMBINATION USE WITH LETROZOLE.

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.

UBRELVY

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, UNLESS TRIPTAN THERAPY IS CONTRAINDICATED, NOT TOLERATED, OR CLINICALLY INAPPROPRIATE DUE TO OTHER CONCURRENT HEALTH CONDITIONS.

VALCHLOR

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	One Year
Other Criteria	COVERAGE FOR TOPICAL TREATMENT OF STAGE 1A AND 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA REQUIRES PRIOR SKIN-DIRECTED THERAPY.

VALTOCO

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

VANFLYTA

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	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 INTERNAL TANDEM DUPLICATION (ITD) POSITIVE REQUIRES USE IN COMBINATION WITH STANDARD CYTARABINE AND ANTHRACYCLINE INDUCTION AND CYTARABINE CONSOLIDATION.

VENCLEXTA

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	One Year
Other Criteria	COVERAGE FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) IN ADULTS 75 YEARS OR OLDER OR WHO HAVE COMORBITITIES THAT PRECLUDE USE OF INTENSIVE INDUCTION CHEMOTHERAPY REQUIRES COMBINATION USE WITH AZACITIDINE, DECITABINE, OR LOW-DOSE CYTARABINE.

VEOZAH

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.

VERQUVO

Products Affected

- Verquvo

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

VERZENIO

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	One Year
Other Criteria	COVERAGE FOR THE ADJUVANT TREATMENT OF ADULT PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, NODE POSITIVE, EARLY BREAST CANCER AT HIGH RISK OF RECUURENCE REQUIRES COMBINATION USE WITH TAMOXIFEN OR AN AROMATASE INHIBITOR. COVERAGE FOR HR-POSITIVE, HER2-NETAGIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION THERAPY WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE BASED THERAPY. COVERAGE FOR HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY REQUIRES COMBINATION USE WITH FULVESTRANT. COVERAGE AS MONOTHERAPY FOR THE TREATMENBT OF ADULT PATIENTS WITH HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR ENDOCRINE AND CHEMOTHERAPY IN THE METASTATIC SETTING.

VIGABATRIN

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

VITRAKVI

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

VIZIMPRO

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

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

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

VORICONAZOLE

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

VOSEVI

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

Products Affected

- Pazopanib 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	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADVANCED TISSUE SARCOMA (STS) REQUIRES PREVIOUS TREATMENT WITH CHEMOTHERAPY.

VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	60 DAYS
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 × 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF EVH WITH PNH REQUIRES COMBINATION USE WITH SOLIRIS OR ULTOMIRIS ONLY.

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH ADVANCED RENAL CELL CARCINOMA (RCC) WITH A CLEAR CELL COMPONENT REQUIRES PRIOR THERAPY WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND A VASCULAR ENDOTHELIAL GROWTH FACTOR TYROSINE KINASE INHIBITOR (VEGF-TKI).

WYOST

Products Affected

- Wyost

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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

XALKORI

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

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): DIAGNOSIS OF ACUTE LYMPHOBLASTIC LEUKEMIA (ALL). POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) (INITIAL): DIAGNOSIS OF ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. TRIAL AND FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE NONSTEROIDAL ANTIINFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN).
Age Restrictions	ALL: PATIENT IS 18 YEARS OF AGE OR YOUNGER. PJIA (INITIAL): PATIENT IS 18 YEARS OF AGE OR YOUNGER.
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A

XCOPRI

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.

XDEMVY

Products Affected

- Xdemvy

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

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
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 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. FOR ALL INDICATIONS: COVERAGE ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITOR (E.G., ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM) 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).

XERMELO

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	COVERAGE FOR THE TREATMENT OF CARCINOID SYNDROME DIARRHEA REQUIRES A TRIAL OF SOMATOSTATIN ANALOG (SSA) THERAPY (E.G., OCTREOTIDE, SOMATULINE).

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.

XOLAIR

Products Affected

- Xolair

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	ALLERGIC ASTHMA: IMMUNOGLOBULIN E (IGE) LEVEL GREATER THAN 30 AND LESS THAN 700 UNITS PER MILLILITER (IU/ML) FOR 12 YEARS AND OLDER, GREATER THAN 30 AND LESS THAN 1300 IU/ML FOR 6 YEARS THROUGH 12 YEARS CRSWNP: IMMUNOGLOBULIN E (IGE) LEVEL BETWEEN 30 AND 1500 IU/ML AT INITIATION OF TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	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 AEROALLEREN. 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 SPONTANEOUS URTICARIA (CSU) REQUIRES DIAGNOSIS OF CSU AND SYMPTOMS DESPITE H1 ANTIHISTAMINE TREATMENT. COVERAGE FOR CSU ALSO REQUIRES 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 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.

XOSPATA

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

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

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	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH MULTIPLE MYELOMA REQUIRES FAILURE OF ONE PRIOR THERAPY. COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TRIAL OF AT LEAST FOUR PRIOR THERAPIES (REFRACTORY TO AT LEAST TWO PROTEASOME INHIBITORS, AT LEAST TWO IMMUNOMODUULATORY AGENTS, AND AN ANTI-CD38 MONOCLONAL ANTIBODY). COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL) REQUIRES TRIAL OF AT LEAST 2 LINES OF SYSTEMIC THERAPY.

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 CASTRATION RESISTANT PROSTATE CANCER (CRPC), METASTATIC CASTRATION RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION SENSITIVE PROSTATE CANCER (MCSPC), AND HIGH-RISK NONMETASTATIC PROSTATE CANCER REQUIRE TRIAL OF ABIRATERONE, USING THE 250MG TABLET STRENGTH

XYREM

Products Affected

- Sodium Oxybate

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	COVERAGE REQUIRES A DIAGNOSIS OF CATAPLEXY OR EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH NARCOLPESY AND, IF 18 YEARS OF AGE OR OLDER, A TRIAL OF ARMODAFINIL AND SUNOSI

ZARXIO

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	One Year
Other Criteria	COVERAGE FOR ACUTE MYELOID LEUKEMIA (AML) REQUIRES PRIOR INDUCTION OR CONSOLIDATION CHEMOTHERAPY TREATMENT.

ZEJULA

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	COVERAGE FOR THE MAINTENANCE TREATMENT OF ADULTS WITH ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER OR FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMPLETE OR PARTIAL RESPONSE TO FIRST-LINE PLATINUM-BASED CHEMOTHERAPY.

ZELBORAF

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

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	COVERAGE FOR METASTATIC SMALL CELL LUNG CANCER (SCLC) REQUIRES DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR THE MAINTENANCE TREATMENT OF EXTENSIVE-STAGE SCLC REQUIRES COMBINATION USE WITH ATEZOLIZUMAB OR ATEZOLIZUMAB AND HYALURONIDASE-TQIS AND CONFIRMATION THE PATIENT'S DISEASE HAS NOT PROGRESSED FOLLOWING FIRST-LINE INDUCTION THERAPY WITH ATEZOLIZUMAB OR ATEZOLIZUMAB AND HYALURONIDASE-TQIS, CARBOPLATIN AND ETOPOSIDE.

ZILBRYSQ

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	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.
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF MYASTHENIA GRAVIS REQUIRES PREVIOUS TREATMENT COURSES OF AT LEAST 12 WEEKS WITH ONE OF THE FOLLOWING 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 REGIMEN.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 FOR THE TREATMENT OF CUTANEOUS MANIFESTATIONS IN PATIENTS WITH CUTANEOUS T-CELL LYMPHOMA WHO HAVE PROGRESSIVE, PERSISTENT OR RECURRENT DISEASE REQUIRES TRIAL OF TWO SYSTEMIC THERAPIES

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

ZTALMY

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

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

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

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

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
- Astagraf XL
- Azathioprine TABS 100MG, 50MG
- Budesonide SUSP
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- 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
- 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
- Ventavis

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

Products Affected

- Abilify Asimtufii

Details

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME

ABILIFY MAINTENA

Products Affected

- Abilify Maintena

Details

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

ANTIDEPRESSANTS

Products Affected

- Exxua
- Exxua Titration Pack
- Trintellix

Details

Criteria	REQUIRES TRIAL OF AT LEAST 2 OF THE FOLLOWING GENERIC DRUGS: BUPROPION, CITALOPRAM, DESVENLAFAXINE, DULOXETINE, ESCITALOPRAM, FLUOXETINE, FLUVOXAMINE, MIRTAZAPINE, NEFAZODONE, PHENELZINE, PROTRIPTYLINE, SERTRALINE, TRANYLCYPROMINE, TRAZODONE, TRIMIPRAMINE, VENLAFAXINE, VILAZODONE. COVERAGE DURATION IS LIFETIME.

ANTIPSYCHOTIC AGENTS

Products Affected

- Caplyta
- Rexulti
- Vraylar
- Zyprexa Relprevv

Details

Criteria	REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, FLUPHENAZINE, HALOPERIDOL, LOXAPINE, LURASIDONE, MOLINDONE, OLANZAPINE INJECTION, PALIPERIDONE, PIMOZIDE, QUETIAPINE, RISPERIDONE, THIORIDAZINE, THIOTHIXENE, TRIFLUOPERAZINE, ZIPRASIDONE. COVERAGE DURATION IS LIFETIME.

ARISTADA

Products Affected

- Aristada

Details

Criteria	REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME

ARISTADA INITIO

Products Affected

- Aristada Initio

Details

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

INSULIN DELIVERY SUPPLIES

Products Affected

- Alcohol Prep Pads PADS 70%
- Curity Gauze Pads 2"x2" 12 Ply

Details

Criteria	COVERAGE REQUIRES A CLAIM FOR AN INSULIN PRODUCT IN THE LAST 180 DAYS. COVERAGE DURATION IS 1 YEAR.

INVEGA HAFYERA

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.

INVEGA SUSTENNA

Products Affected

- Invega Sustenna

Details

Criteria	REQUIRES TRIAL OF ORAL PALIPERIONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.

INVEGA TRINZA

Products Affected

- Invega Trinza

Details

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

PERSERIS

Products Affected

- Perseris

Details

Criteria	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME

RHOPRESSA

Products Affected

- Rhopressa

Details

Criteria	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.

RISPERDAL CONSTA

Products Affected

- Risperidone Er

Details

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

ROCKLATAN

Products Affected

- Rocklatan

Details

Criteria	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.

RYKINDO

Products Affected

- Rykindo

Details

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

RYTARY

Products Affected

- Rytary

Details

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

ULORIC

Products Affected

- Febuxostat

Details

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

VYTORIN

Products Affected

- Ezetimibe/simvastatin

Details

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