Blue Cross Blue Shield Blue Care Network of Michigan

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Medicare Plus Blue℠ Group PPO
UAW Trust Comprehensive Formulary
Prior Authorization / Step Therapy Program
2023 Plan Year
Updated 12/1/2023

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

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

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

H9572_UAW23DecPAST_C FVNR 1123

ABIRATERONE - UAW TRUST

Products Affected

- Abiraterone Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer. One of the following: 1) Disease is metastatic, 2) Disease is regional node positive (e.g., Any T, N1, M0), 3) Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT), or 4) Positive pelvic persistence/recurrence after prostatectomy. Used in combination with prednisone or dexamethasone. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ABRAXANE - UAW TRUST

Products Affected

- Abraxane
- Paclitaxel Protein-bound Particles

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of metastatic breast cancer. One of the following: a) patient has failed combination chemotherapy for metastatic disease, or b) disease has relapsed within 6 months of adjuvant chemotherapy. Prior therapy included an anthracycline (e.g., doxorubicin, epirubicin) unless contraindicated. One of the following: a) chart documentation of a previous hypersensitivity reaction despite premedication for one of the following: Onxol (paclitaxel) or Taxotere (docetaxel), or b) chart documentation of contraindication to any one of the following standard premedications used to prevent hypersensitivity reactions to Onxol (paclitaxel) or Taxotere (docetaxel): H1 blocker [eg, Benadryl (diphenhydramine)], Decadron (dexamethasone), or H2 antagonist [eg, Pepcid (famotidine), Tagamet (cimetidine), Zantac (ranitidine)]. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of locally advanced or metastatic NSCLC. Used in combination with carboplatin. Patient is not a candidate for curative surgery or radiation therapy. One of the following: a) chart documentation of a previous hypersensitivity reaction despite premedication for one of the following: Onxol (paclitaxel) or Taxotere (docetaxel), or b) chart documentation of contraindication to any one of the following standard premedications used to prevent hypersensitivity reactions to Onxol (paclitaxel) or Taxotere (docetaxel): H1 blocker [eg, Benadryl (diphenhydramine)], Decadron (dexamethasone), or H2 antagonist [eg, Pepcid (famotidine), Tagamet (cimetidine), Zantac (ranitidine)]. Adenocarcinoma of the pancreas: Diagnosis of adenocarcinoma of the pancreas. Disease is metastatic. Used in combination with gemcitabine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ABRYSVO

Products Affected

- Abrysvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV). Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy) in the previous 2 years. One of the following: 1) Age greater than or equal to 60 years, OR 2) Both of the following: a) Will be used for active immunization of pregnant individuals at 32 through 36 weeks gestational age, and b) Will also be used for the prevention of severe LRTD caused by RSV in infants from birth through 6 months of age.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months (1 injection per 2 years)
Other Criteria	N/A

ACTEMRA IV - UAW TRUST

Products Affected

- Actemra INJ 200MG/10ML, 400MG/20ML, 80MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for the treatment of Coronavirus Disease 2019 (COVID-19) in hospitalized adult.
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary Adalimumab product (i.e., Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) for continuation of prior therapy if within the past 180 days. Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: a) minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), b) minimum duration of a 3-month trial of methotrexate, or c) minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: 1) TF/C/I to two of the following: Enbrel (etanercept), Formulary Adalimumab product (i.e., Humira, Cyltezo, Yuflyma), Xeljanz (tofacitinib), OR 2) for continuation of prior therapy if within the past 180 days. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Cytokine Release Syndrome (CRS) Risk due to CAR T-cell Therapy: Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [i.e., Kymriah (tisagenlecleuce), Yescarta (axicabtagene ciloleucel)].
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA, GCA (Initial): Prescribed by or in consultation with a rheumatologist. Cytokine Release Syndrome (CRS) Risk due to CAR T-cell Therapy: Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	RA, SJIA, PJIA, GCA: 6 mo (init), plan year (reauth). CRS risk due to CAR T-cell therapy: 2 months
Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR

	improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GCA (Reauth): Documentation of positive clinical response to therapy.

ACTEMRA SC - UAW TRUST

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) for continuation of prior therapy if within the past 180 days. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (e.g., prednisone). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: a) minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), b) minimum duration of a 3-month trial of methotrexate, or c) minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: 1) TF/C/I to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Xeljanz (tofacitinib), OR 2) for continuation of prior therapy if within the past 180 days. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.
Age Restrictions	N/A
Prescriber Restrictions	RA, GCA, SJIA, PJIA (Initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (Initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): plan year.

Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GCA, SSc-ILD (Reauth): Documentation of positive clinical response to therapy.

ACTHAR - UAW TRUST

Products Affected

- Acthar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Plan will not cover any of the following: Scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, history of or presence of peptic ulcer, CHF, uncontrolled HTN, primary adrenocorticoid insufficiency or adrenocorticoid hyperfunction
Required Medical Information	Diagnosis, medical history, current therapies, and for all diagnosis other than infantile spasm - chart notes detailing the outcomes of the most recent trial of a systemic corticosteroid (e.g., prednisone, IV methylprednisolone), including dosage and duration of treatment
Age Restrictions	Infantile spasm - less than 2 years of age.
Prescriber Restrictions	Infantile spasm and MS - prescribed by neurologist. Nephrotic syndrome - prescribed by nephrologist. Dermatology conditions - prescribed by dermatologist. Ophthalmic conditions - prescribed by ophthalmologist. Rheumatic disorders and collagen disease - prescribed by rheumatologist. Respiratory disease - prescribed by pulmonologist. Serum sickness - prescribed by allergist or immunologist.
Coverage Duration	Initial auth for MS-3 wks. Initial auth for others-4 wks. Reauth except infant spasms and MS-3 mos.
Other Criteria	Relapsing MS - patient is experiencing an acute exacerbation AND is currently on a disease modifying relapsing remitting MS agent (e.g., glatiramer, dimethyl fumarate, Gilenya) or has a documented contraindication or intolerance to 2 or more disease modifying agents or this is the initial MS occurrence (the patient had no previous MS diagnosis) AND has failed a systemic corticosteroid (e.g., prednisone, IV methylprednisolone) in the past 30 days. Nephrotic syndrome - patient has documented proteinuria greater than or equal to 3 grams/24 hours (not due to uremia of idiopathic type or lupus erythematous) AND patient has failed a systemic corticosteroid (e.g., prednisone, IV methylprednisolone) in the past 30 days. Psoriatic arthritis, rheumatoid arthritis, or ankylosing spondylitis - patient is experiencing an acute exacerbation AND is currently on a DMARD (e.g., methotrexate, sulfasalazine) or has a documented contraindication or intolerance to 2 or more DMARDS AND has failed a systemic corticosteroid (e.g., prednisone, IV methylprednisolone) in the past 30 days. Other indications (excluding infantile spasms) - patient has failed a systemic corticosteroid (e.g.,

	prednisone, IV methylprednisolone) in the past 30 days. Reauthorization for all indications other than infantile spasms or MS will be for 3 months if documentation provided regarding improvement in clinical signs and symptoms.

ADAKVEO

Products Affected

- Adakveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Sickle Cell Disease. Documentation of 2 vaso-occlusive events that required medical facility visits and treatments in the past 12 months (e.g., sickle cell crisis, acute pain episodes, acute chest syndrome, hepatic sequestration, splenic sequestration, priapism). Trial and failure or inadequate response, contraindication, or intolerance to one of the following: 1) Hydroxyurea or 2) L-glutamine (i.e., Endari).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: 1) Hematologist/Oncologist or 2) Specialist w/ expertise in the diagnosis and management of sickle cell disease.
Coverage Duration	Initial, Reauth: Plan Year
Other Criteria	Reauth: Documentation of positive clinical response to therapy (e.g., reduction in annual rate of vaso-occlusive events, increased time between each vaso-occlusive event).

ADCETRIS - UAW TRUST

Products Affected

- Adcetris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Pulmonary arterial hypertension (PAH): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: plan 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	Episodic Migraines (EM) (initial): Diagnosis of EM with both of the following: 1) Less than 15 headache days per month and 2) Patient has 4 to 14 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) Topiramate (Topamax), e) Venlafaxine (Effexor), f) Candesartan (Atacand). Chronic Migraines (CM) (initial): Diagnosis of CM with both of the following: 1) Greater than or equal to 15 headache days per month and 2) Greater than or equal to 8 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) OnabotulinumtoxinA (Botox), e) Topiramate (Topamax), f) Venlafaxine (Effexor), g) Candesartan (Atacand). All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial, reauth): Plan year.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

AJOVY

Products Affected

- Ajovy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM with both of the following: 1) Less than 15 headache days per month and 2) Patient has 4 to 14 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM with both of the following: 1) Greater than or equal to 15 headache days per month and 2) Greater than or equal to 8 migraine days per month. All Indications (initial): Trial and failure, contraindication, or intolerance to Aimovig (erenumab-aooe) and Emgality (galcanezumab-gnlm). Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial, reauth): Plan year.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

ALECENSA - UAW TRUST

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic, recurrent, or advanced NSCLC. Patient has anaplastic lymphoma kinase (ALK)-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ALIMTA - UAW TRUST

Products Affected

- Alimta
- Pemetrexed
- Pemetrexed Disodium

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of locally advanced or metastatic nonsquamous NSCLC. Prior history of first-line chemotherapy treatment for NSCLC (Avastin [bevacizumab] in combination with chemotherapy, or platinum-based combination chemotherapy), or used in combination with Platinol (cisplatin) or Paraplatin (carboplatin), or tumor response or stable disease after 4 cycles of first-line platinum-based chemotherapy, or used as first-line monotherapy in patients 70 years of age or greater, or used as first-line monotherapy in patients less than 70 and not eligible for platinum-based chemotherapy (eg, poor performance status or comorbidities). Mesothelioma: Diagnosis of malignant pleural mesothelioma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ALIQOPA - UAW TRUST

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma AND patient has received at least two prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ALPHA - 1 PROTEINASE INHIBITORS

Products Affected

- Aralast Np INJ 1000MG, 500MG
- Glassia
- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. One of the following: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) protein phenotypes (homozygous) or Other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µmol/L [eg, Pi(Malton, Malton), Pi(SZ)]. One of the following: 1) Circulating pre-treatment serum AAT level less than 11 µmol/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry), or 2) Patient has a concomitant diagnosis of necrotizing panniculitis. Continued conventional treatment for emphysema (eg, bronchodilators).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): plan year
Other Criteria	AAT deficiency (reauth): Documentation of positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

ALUNBRIG - UAW TRUST

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic, recurrent, or advanced NSCLC and tumor is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

AMBRISENTAN

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

APOMORPHINE INJECTION

Products Affected

- Apomorphine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not used with any 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron).
Required Medical Information	Parkinson's disease diagnosis. Unable to control off symptoms with one conventional oral therapy [eg, Comtan (entacapone), Mirapex (pramipexole), Requip (ropinirole), Sinemet (carbidopa/levodopa), Stalevo (carbidopa/levodopa/entacapone), amantadine, Tasmar (tolcapone)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ARANESP

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD) (Initial): Diagnosis of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) within 30 days of request. The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. (Reauth): Diagnosis of CKD. Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis, without ESRD OR Most recent or average (avg) Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis OR Most recent or average (avg) Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Documentation of a positive clinical response to therapy from pre-treatment level. Anemia w/ chemo (Initial): Other causes of anemia ruled out. Anemia w/ labs (Hct less than 30%, Hgb less than 10 g/dL) within prior 2 weeks of request. Cancer is non-myeloid malignancy. Patient is receiving chemo. (Reauth): Anemia by labs (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Documentation of a positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. Anemia in MDS (Init): Diagnosis of MDS. Serum erythropoietin 500 mU/mL or less, or transfusion dependent MDS. (Reauth): Most recent or avg Hct over 3 months was 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Documentation of a positive clinical response to therapy from pre-treatment level.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD(Init): 6 mo. CKD(reauth):plan yr. Chemo(init, reauth): 3 mo. MDS(init): 3 mo,(reauth): plan yr
Other Criteria	ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following indications:

	Off-label uses (except Anemia in Myelodysplastic Syndrome (MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.CKD (init, reauth), Chemo (init), MDS (init): Verify Fe eval for adequate Fe stores.

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	Cryopyrin-Associated Period Syndromes (CAPS): Diagnosis of CAPS, Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. Patient weighs at least 10 kg. Patient is currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L). Recurrent Pericarditis (initial): Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart. Trial and failure, contraindication, or intolerance (TF/C/I) to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CAPS, DIRA: plan year. Recurrent Pericarditis (initial, reauth): plan year.
Other Criteria	Recurrent Pericarditis (reauth): Documentation of positive clinical response to therapy.

AREXVY

Products Affected

- Arexvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV). Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy) in the previous 2 years. Age greater than or equal to 60 years.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months (1 injection per 2 years)
Other Criteria	N/A

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	Mycobacterium avium complex (MAC) lung disease: Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	Plan year
Other Criteria	N/A

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial): Dx of SWD confirmed by one of the following: 1) Symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: Plan Year
Other Criteria	OSA, Narcolepsy (Reauth): Documentation of positive clinical response to therapy. SWD (Reauth): Documentation of positive clinical response to therapy.

AVASTIN - UAW TRUST

Products Affected

- Avastin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Non-Small Cell Lung Cancer: Excluded if squamous cell histology.
Required Medical Information	Colorectal Cancer: Diagnosis of metastatic colorectal cancer. Used in combination with one of the following: 5-fluorouracil (5-FU), oxaliplatin, capecitabine, irinotecan, CapeOx (capecitabine and oxaliplatin), 5-FU/LV (fluorouracil and leucovorin), Fluoropyrimidine (eg, capecitabine, floxuridine, fluorouracil)-irinotecan-based therapy, Fluoropyrimidine (eg, capecitabine, floxuridine, fluorouracil)-oxaliplatin-based therapy. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of unresectable locally advanced recurrent or metastatic NSCLC. Used in combination with paclitaxel and carboplatin. Renal Cell Cancer: Diagnosis of metastatic renal cell cancer. Used in combination with interferon-alpha. Breast Cancer: Diagnosis of breast cancer. Used in combination with paclitaxel. Age-related Macular Degeneration (ARMD): Diagnosis of age-related macular degeneration. Macular Edema: Diagnosis of macular edema following retinal vein occlusion. Glioblastoma: Diagnosis of glioblastoma. Disease is recurrent. Cervical Cancer: Diagnosis of persistent, recurrent, or metastatic carcinoma of the cervix. Used in combination with one of the following: paclitaxel/cisplatin or paclitaxel/topotecan. Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. One of the following: A) All of the following: Disease is stage 3 or 4, patient has been treated with bevacizumab as a single agent, treatment is following surgical resection, used in combination with carboplatin and paclitaxel, OR B) All of the following: Disease is platinum-resistant recurrent, patient has received no more than 2 prior chemotherapy regimens, used in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan, OR C) All of the following: Disease is platinum-sensitive recurrent, patient has been treated with bevacizumab as a single agent, used in combination with carboplatin/paclitaxel or carboplatin/gemcitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan year
Other Criteria	Hepatocellular Carcinoma (HCC): Diagnosis of hepatocellular carcinoma. Disease is unresectable or metastatic. Used in combination with Tecentriq (atezolizumab). Patient has not received prior systemic therapy. Approve for continuation of prior therapy if within the past 180 days.

AYVAKIT - UAW TRUST

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. One of the following: 1) Used as a single agent for continued treatment for limited progression OR 2) Both of the following: a) Disease is one of the following: i) unresectable, ii) metastatic, iii) recurrent, iv) persistent microscopic or gross residual disease, v) residual disease with significant morbidity, vi) limited progression, or vii) resectable with significant morbidity AND b) Presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Systemic Mastocytosis: Both of the following: 1) Diagnosis of one of the following: a) advanced systemic mastocytosis (AdvSM), b) aggressive systemic mastocytosis (ASM), c) systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or d) mast cell leukemia (MCL) AND 2) platelet count is greater than 50 x 10^9/L. Ayvakit 25 mg - Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

AZACITIDINE - UAW TRUST

Products Affected

- Azacitidine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic Syndromes (MDS): Diagnosis of one of the following MDS subtypes: a) refractory anemia (RA), OR b) refractory anemia with ringed sideroblasts (RARS) AND RARS is accompanied by neutropenia, thrombocytopenia, or requiring transfusions, OR c) refractory anemia with excess blasts (RAEB), OR d) refractory anemia with excess blasts in transformation (RAEB-T), or e) chronic myelomonocytic leukemia (CMMoL). Juvenile Myelomonocytic Leukemia (JMML): Diagnosis of JMML. Patient is newly diagnosed.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BALVERSA - UAW TRUST

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). One of the following: Locally advanced or metastatic. Patient has fibroblast growth factor receptor (FGFR) 3 or FGFR2 genetic alterations. One of the following: 1) Patient has progressed during or following at least one line of prior chemotherapy (e.g., gemcitabine with cisplatin or carboplatin, dose dense methotrexate vinblastine doxorubicin cisplatin [DDMVAC] with growth factor support, etc.) or immunotherapy (e.g., avelumab, atezolizumab, etc.) OR 2) Patient has progressed within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy (e.g., [DDMVAC] with growth factor support, gemcitabine with cisplatin, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BAVENCIO - UAW TRUST

Products Affected

- Bavencio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Merkel Cell Carcinoma (MCC): Diagnosis of metastatic Merkel cell carcinoma. Urothelial Carcinoma (UC): Diagnosis of locally advanced or metastatic urothelial carcinoma. One of the following: 1) Patient has disease progression during or following platinum-containing chemotherapy (e.g., cisplatin, carboplatin), OR 2) Patient has disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy (e.g., cisplatin, carboplatin), OR 3) Both of the following: a) Used as maintenance treatment and b) patient has not progressed with first-line platinum-containing chemotherapy (e.g., cisplatin, carboplatin). Renal Cell Carcinoma (RCC): Diagnosis of advanced renal cell carcinoma. Used as first-line treatment in combination with Inlyta (axitinib).
Age Restrictions	MCC: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

BENDEKA - UAW TRUST

Products Affected

- Belrapzo
- Bendeka

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic lymphocytic leukemia (CLL. non-Hodgkin's lymphoma (NHL): Diagnosis of indolent non-Hodgkin's lymphoma (NHL). Patient is refractory during or within six months of treatment with rituximab or rituximab-containing regimen
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BENLYSTA SQ - UAW TRUST

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	Systemic Lupus Erythematosus (SLE) (Initial): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)]). Lupus Nephritis (Initial): Diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide). SLE, Lupus Nephritis (Reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SLE, Lupus Nephritis (initial): 6 months. SLE, Lupus Nephritis (reauth): Plan Year
Other Criteria	N/A

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE: Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Plan year
Other Criteria	N/A

BESPONSA - UAW TRUST

Products Affected

- Besponsa

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 B-cell precursor acute lymphoblastic leukemia (ALL). Disease is relapsed or refractory
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BESREMI - UAW TRUST

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of polycythemia vera as confirmed by all of the following: 1) One of the following: a) Hemoglobin greater than 16.5 g/dL for men or hemoglobin greater than 16.0 g/dL for women, b) Hematocrit greater than 49% for men or hematocrit greater than 48% for women, or c) Increased red cell mass, AND 2) Bone marrow biopsy showing hypercellularity for age with trilineage growth (panmyelosis) including prominent erythroid, granulocytic and megakaryocytic proliferation with pleomorphic, mature megakaryocytes, AND 3) One of the following: a) Presence of JAK2 or JAK2 exon 12 mutation or b) Subnormal serum erythropoietin level. Both of the following: 1) Trial and failure, contraindication or intolerance (TF/C/I) to hydroxyurea, AND 2) TF/C/I to one interferon therapy (e.g., Intron A, Pegasys, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BEXAROTENE - UAW TRUST

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of cutaneous T-cell lymphoma (CTCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BORTEZOMIB - UAW TRUST

Products Affected

- Bortezomib
- Velcade

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of mantle cell lymphoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BOSENTAN

Products Affected

- Bosentan
- Tracleer TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist
Coverage Duration	PAH: Plan year
Other Criteria	N/A

BOSULIF - UAW TRUST

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuromuscular Disorders (init): One of the following: Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), treatment of spasticity, VII cranial nerve disorders (hemifacial spasms), or cervical dystonia. Hyperhidrosis(HH) (Init): Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Migraine (Init): Diagnosis of CM with both of the following: 1) Greater than or equal to 15 headache days per month and 2) Greater than or equal to 8 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) Topiramate (Topamax), e) Venlafaxine (Effexor), f) Candesartan (Atacand). Achalasia (Init): High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of either nocturnal pain and bleeding or postdefecation pain. Chronic Back Pain (CBP) (Init): Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI) (init): Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis, spinal dysraphisms such as spina bifida) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB) (init): Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.
Age Restrictions	N/A
Prescriber Restrictions	Migraine (Initial): Prescribed by or in consultation with one of the following specialists with expertise in the treatment of chronic migraine: neurologist, pain specialist, headache specialist. CBP (Initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.
Coverage Duration	Achalasia: 6moCBP:1 tx(series of injxs)UI:3mo Other:3mo

Other Criteria	UI, OAB, CBP, Neuromuscular Disorders (Reauth): Documentation of positive clinical response to therapy. At least 3 months have or will have elapsed since the last treatment. HH (Reauth): At least a 2-point improvement in HDSS. Migraine (Reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Achalasia (Reauth): Documentation of positive clinical response to therapy (e.g., reduction in dysphagia, regurgitation, chest pain). At least 6 months have or will have elapsed since last series of injections. AF (Reauth): Incomplete healing of fissure or recurrence of fissure. Documentation of positive clinical response to therapy.

BRAFTOVI - UAW TRUST

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	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Patient is positive for BRAF V600 mutation. Used in combination with Mektovi (binimetinib). Colorectal Cancer: One of the following diagnoses: Colon Cancer or Rectal Cancer. One of the following: 1) Unresectable or advanced disease or 2) Metastatic disease. Patient has received prior therapy. Patient is positive for BRAF V600E mutation. Used in combination with one of the following: 1) Erbitux (cetuximab) or 2) Vectibix (panitumumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

BRIVIACT - UAW TRUST

Products Affected

- Briviact

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Partial-onset seizures: Diagnosis of partial-onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

BRUKINSA - UAW TRUST

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Patient has received at least one prior therapy for MCL. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed or refractory. Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Acquired thrombotic thrombocytopenic purpura (aTTP): Diagnosis of aTTP. First dose was/will be administered by a healthcare provider as a bolus intravenous injection. Used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids). One of the following: 1) Used in combination with plasma exchange or 2) both of the following: patient has completed plasma exchange and less than 59 days have or will have elapsed beyond the last plasma exchange.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

CABOMETYX - UAW TRUST

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced RCC. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. One of the following: a) Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate), or b) Patient has metastatic disease, or c) Patient has extensive liver tumor burden, or d) Patient is inoperable by performance status or comorbidity, or has local disease or local disease with minimal extrahepatic disease only, or e) Both of the following: patient is not a transplant candidate and disease is unresectable. Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Disease is one of the following: a) locally advanced or b) metastatic. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease is radioactive iodine-refractory or ineligible.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

CALQUENCE - UAW TRUST

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND patient has received at least one prior therapy for MCL. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

CAPLYTA - UAW TRUST

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral, single-ingredient, formulary, generic atypical antipsychotics: aripiprazole (tablet or solution), clozapine tablet, olanzapine tablet, quetiapine IR tablet, risperidone (tablet or solution), ziprasidone capsule. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

CAPRELSA - UAW TRUST

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of unresectable locally advanced or metastatic medullary thyroid cancer
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Diagnosis of type 1 Gaucher disease. Patients must be CYP2D6 extensive metabolizers (EMs), intermediate metabolizers (IMs), or poor metabolizers (PMs) as detected by an FDA-cleared test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of radiolucent gallstones. Patient has a well-opacifying gallbladder visualized by oral cholecystography. Trial and failure, contraindication or intolerance to ursodiol. Patient is not a candidate for surgery. Stones are not calcified (radiopaque) or radiolucent bile pigment stones.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: Plan year
Other Criteria	Reauth: Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by Oral cholecystograms or ultrasonograms.

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of peroxisomal disorder, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) Will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	Initial: 3 months Reauth: Plan year
Other Criteria	All uses (reauth): documentation of positive clinical response to therapy as evidenced by improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT]).

CHORIONIC GONADOTROPIN

Products Affected

- Novarel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used to promote fertility.
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and low LH (below normal reference value provided by the physician's laboratory) or FSH (below normal reference value provided by the physician's laboratory). Hypogonadotropic Hypogonadism (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. Male Hypogonadotropic Hypogonadism (initial, reauth): plan yr
Other Criteria	N/A

CIMZIA - UAW TRUST

Products Affected

- Cimzia
- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA): Diagnosis (dx) of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Crohn's Disease (CD): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. One of the following: TF/C/I to two of the following: Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR for continuation of prior therapy if within the past 180 days. Psoriatic Arthritis (PsA): Dx of active psoriatic arthritis. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [Xeljanz/Xeljanz XR or Rinvoq], OR for continuation of prior therapy if within the past 180 days. Ankylosing Spondylitis (AS): Dx of active AS. TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx], JAK [Rinvoq, Xeljanz/Xeljanz XR], OR for continuation of prior therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	CD (initial): Prescribed by or in consultation with a gastroenterologist. RA, AS, nr-axSpA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.

Coverage Duration	All indications (initial): 6 months, (reauth): plan year
Other Criteria	Plaque Psoriasis (initial): Dx of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx], IL-23 [Stelara or Skyrizi]. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of nr-axSpA with signs of inflammation. Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. CD (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE (prophylaxis): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Plan year
Other Criteria	N/A

CLONIDINE ER

Products Affected

- Clonidine Hydrochloride Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of attention deficit hyperactivity disorder (ADHD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

COMETRIQ - UAW TRUST

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medullary Thyroid Cancer (MTC): Diagnosis of metastatic medullary thyroid cancer (MTC).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

COPIKTRA - UAW TRUST

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease is relapsed or refractory. Trial and failure, contraindication, or intolerance to at least two prior therapies for CLL/SLL [e.g., Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), etc.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

CORLANOR - UAW TRUST

Products Affected

- Corlanor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of heart failure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Heart failure (HF) in adults not currently receiving Corlanor - must meet all of the following: 1. left ventricular ejection fraction (LVEF) of less than or equal 35 percent, 2. sinus rhythm and a resting heart rate (HR) of greater than or equal to 70 beats per minute (BPM), AND 3. tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as chronic obstructive pulmonary disease (COPD) and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy. HF due to dilated cardiomyopathy in pediatric patients - must have LVEF of less than or equal to 45 percent and a resting HR stratified by age from 70 to 105 BPM.

COSENTYX - UAW TRUST

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	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR 2) for continuation of prior therapy if within the past 180 days. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: 1) TF/C/I to one of the following: Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Skyrizi, Stelara, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) for continuation of prior therapy if within the past 180 days. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one non-steroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. One of the following: 1) TF/C/I to one of the following: Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq, or Xeljanz/Xeljanz XR, OR 2) for continuation of prior therapy if within the past 180 days. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with signs of inflammation. Minimum duration of a one-month TF/C/I to two NSAIDs (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. Psoriatic Arthritis (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.

Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): plan year.
Other Criteria	Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. Minimum duration of a one-month TF/C/I to two NSAIDs (eg, ibuprofen, naproxen) at maximally tolerated doses. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline.

COTELLIC - UAW TRUST

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Disease is positive for BRAF V600E or V600K mutation. Used in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of one of the following: 1) Langerhans Cell Histiocytosis, 2) Erdheim-Chester Disease, or 3) Rosai-Dorfman Disease. One of the following: 1) Mitogen-activated protein (MAP) kinase pathway mutation, 2) No detectable mutation, or 3) Testing not available.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

CRESEMBA

Products Affected

- Cresemba

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CRYSVITA - UAW TRUST

Products Affected

- Crysvita

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	X-Linked Hypophosphatemia (XLH): Diagnosis of X-linked hypophosphatemia. One of the following: a) Patient is 6 months to 17 years of age or b) Both of the following: Patient is 18 years of age or older, AND patient is a candidate for pharmacologic therapy by meeting one of the following: spontaneous insufficiency fractures, pending orthopedic procedures (e.g., joint replacement), biochemical evidence of osteomalacia (i.e., elevated serum alkaline phosphatase), OR disabling skeletal pain. Trial and failure, contraindication, or intolerance to conventional treatment with phosphate supplementation and vitamin D analog-based therapy (e.g., calcitriol, paricalcitol, doxercalciferol). Tumor-Induced Osteomalacia (TIO) (Initial): Diagnosis of FGF23-related hypophosphatemia in TIO. Tumor could not be curatively resected or localized. Trial and failure, contraindication, or intolerance to conventional treatment with phosphate supplementation and vitamin D analog-based therapy (e.g., calcitriol, paricalcitol, doxercalciferol).
Age Restrictions	TIO (initial): Patient is at least 2 years of age.
Prescriber Restrictions	XLH: Prescribed by or in consultation with one of the following: a) Endocrinologist or b) Specialist experienced in the treatment of inborn errors of metabolism or c) nephrologist. TIO: Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist.
Coverage Duration	XLH, TIO (Initial, Reauth): Plan Year
Other Criteria	XLH (Reauth): Documentation of positive clinical response to therapy (e.g., improvement in rickets, improvement in serum phosphorus or Radiographic Global Impression of Change [RGI-C] scores). TIO (Reauth): Documentation of positive clinical response to therapy (e.g., increase in serum phosphorus level, improvement in osteoid thickness, osteoid surface, osteoid volume, mineralization lag time, or improvement as indicated by bone biopsy).

CYLTEZO

Products Affected

- Cyltezo
- Cyltezo Starter Package For Crohns Disease/uc/hs
- Cyltezo Starter Package For Psoriasis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): Diagnosis (Dx) of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate (MTX), leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): Dx of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA)(Initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (PSO)(Initial): Dx of moderate to severe chronic PSO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD)(Initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine (6-MP), azathioprine, corticosteroid (eg, prednisone), MTX.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, JIA: (Initial) Prescribed by or in consultation with a rheumatologist. PsA: (Initial) Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS: (Initial) Prescribed by or in consultation with a dermatologist. CD, UC: (Initial) Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC: (Initial) 12 wks. Other uses (initial): 6 months. All uses (reauth): plan year.

Other Criteria	Ulcerative Colitis (UC) (Initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-MP, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Hidradenitis suppurativa (HS) (Initial): Dx of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Documentation of positive clinical response to therapy. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

DANYELZA - UAW TRUST

Products Affected

- Danyelza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuroblastoma: Diagnosis of high-risk neuroblastoma in bone or bone marrow. Disease is relapsed or refractory. Used in combination with granulocyte-macrophage colony-stimulating factor [e.g., Leukine (sargramostim)]. Patient has had prior therapy with one of the following responses: partial response, minor response, or stable disease.
Age Restrictions	Neuroblastoma: Patient is 1 year of age or older.
Prescriber Restrictions	Neuroblastoma: Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

DARZALEX - UAW TRUST

Products Affected

- Darzalex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapse/Refractory Multiple myeloma: Diagnosis of multiple myeloma. One of the following: a) Both of the following: Used as monotherapy and One of the following: 1) Patient has received at least three prior treatment regimens which included both of the following: proteasome inhibitor (eg, bortezomib [Velcade], carfilzomib [Kyprolis]) and immunomodulatory agent (eg, lenalidomide [Revlimid], thalidomide [Thalomid]), or 2) Patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent, or b) Both of the following: used in combination with one of the following treatment regimens: lenalidomide and dexamethasone, or bortezomib and dexamethasone, or carfilzomib and dexamethasone AND patient has received at least one prior therapy (eg, bortezomib [Velcade], carfilzomib [Kyprolis], ixazomib [Ninlaro], lenalidomide [Revlimid], thalidomide [Thalomid]), or c) Both of the following: used in combination with both pomalidomide and dexamethasone, AND patient has received at least two prior therapies including lenalidomide and a proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]). Newly Diagnosed Multiple Myeloma: Newly diagnosed multiple myeloma. One of the following: A) Both of the following: patient is ineligible for autologous stem cell transplant AND one of the following: 1) used in combination with all of the following: bortezomib, melphalan, and prednisone or 2) used in combination with both of the following: lenalidomide and dexamethasone. OR B) Both of the following: patient is eligible for autologous stem cell transplant AND used in combination with all of the following: bortezomib, thalidomide, and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

DARZALEX FASPRO - UAW TRUST

Products Affected

- Darzalex Faspro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed/Refractory Multiple Myeloma (MM): Diagnosis of MM. One of the following: a) Both of the following: Used as monotherapy and One of the following: 1) Patient has received at least three prior treatment regimens which included both of the following: proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]) and immunomodulatory agent (e.g., lenalidomide [Revlimid], thalidomide [Thalomid]), or 2) Patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent, or b) Both of the following: used in combination with one of the following treatment regimens: lenalidomide and dexamethasone, or bortezomib and dexamethasone, or carfilzomib and dexamethasone, AND patient has received at least one prior therapy (e.g., bortezomib [Velcade], carfilzomib [Kyprolis], ixazomib [Ninlaro], lenalidomide [Revlimid], thalidomide [Thalomid), or c) Both of the following: used in combination with both pomalidomide and dexamethasone, AND patient has received at least one prior line of therapy including lenalidomide and a proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]). Newly Diagnosed MM: Newly diagnosed MM. One of the following: A) Both of the following: patient is ineligible for autologous stem cell transplant AND one of the following: 1) used in combination with all of the following: bortezomib, melphalan, and prednisone or 2) used in combination with both of the following: lenalidomide and dexamethasone. OR B) Both of the following: patient is eligible for autologous stem cell transplant AND used in combination with all of the following: bortezomib, thalidomide, and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Light Chain (AL) Amyloidosis: Newly diagnosed light chain (AL) amyloidosis. Used in combination with all of the following: bortezomib,

	cyclophosphamide, and dexamethasone. All of the following: patient does not have New York Association (NYHA) Class IIIB disease, patient does not have NYHA class IV disease, and patient does not have Mayo Stage IIIB disease. All uses: Approve for continuation of prior therapy if within the past 180 days.

DAURISMO - UAW TRUST

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute myeloid leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND Daurismo therapy to be given in combination with low-dose cytarabine AND One of the following: 1) Patient is greater than or equal to 75 years old, or 2) Patient has significant comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

DEFERASIROX

Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload due to Blood Transfusions (initial): Diagnosis of chronic iron overload (eg, sickle cell anemia, thalassemia, etc.) due to blood transfusion. Patient has blood transfusion of at least 100 mL/kg of packed red blood cells (eg, at least 20 units of packed red blood cells for a 40-kg person or more in individuals weighing more than 40 kg) prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently greater than 1000 mcg/L prior to initiation of treatment with deferasirox. Chronic Overload in non-transfusion dependent thalassemia syndromes (initial): Diagnosis of chronic iron overload in non-transfusion dependent thalassemia syndrome. Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently more than 300 mcg/L prior to initiation of treatment with deferasirox. Chronic Iron Overload due to Blood Transfusions, Chronic Overload in non-transfusion dependent thalassemia syndromes (reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a hematologist/oncologist or hepatologist.
Coverage Duration	Plan year
Other Criteria	N/A

DEFERIPRONE

Products Affected

- Deferiprone
- Ferriprox SOLN
- Ferriprox TABS 1000MG
- Ferriprox Twice-a-day

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transfusional iron overload: Diagnosis of transfusional iron overload due to one of the following: thalassemia syndromes, sickle cell disease, other transfusional-dependent anemia. Absolute Neutrophil Count (ANC) greater than 1.5 x 10^9/L. One of the following: A) Trial and failure to one chelation therapy (e.g., generic deferasirox) OR B) History of contraindication or intolerance to one chelation therapy (e.g., generic deferasirox).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	All uses (reauth): Documentation of positive clinical response to therapy. ANC greater than 1.5 x 10^9/L.

DEGARELIX - UAW TRUST

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

DOXEPIN TOPICAL

Products Affected

- Doxepin Hydrochloride CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of moderate pruritus. Patient has atopic dermatitis or lichen simplex chronicus. Trial and failure, contraindication, or intolerance to at least one medium potency topical corticosteroid, or is not a candidate for topical corticosteroids (e.g., treatment is on face, axilla, or groin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

DRIZALMA - UAW TRUST

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of major depressive disorder (MDD) or diagnosis of generalized anxiety disorder (GAD)
Age Restrictions	MDD - 18 years of age and older. GAD - 7 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. MDD and GAD - documented swallowing difficulty that requires duloxetine to be administered over applesauce or via nasogastric tube.

DROXIDOPA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurogenic orthostatic hypotension (NOH): (Initial): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with one of the following specialists: cardiologist, neurologist, nephrologist.
Coverage Duration	Initial: 1 month. Reauth: plan year
Other Criteria	Trial and failure, contraindication, or intolerance to one of the following agents: Fludrocortisone acetate, midodrine.

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	Initial: Diagnosis of asthma. Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age), or intolerance to two of the following: one fluticasone propionate-salmeterol product (e.g., Advair), Breo Ellipta, or Symbicort.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: Plan year.
Other Criteria	Reauth: 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	N/A
Required Medical Information	Atopic Dermatitis (AD) (initial): Diagnosis (dx) of chronic AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication (eg, safety concerns, not indicated for patient's age/weight), or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. Eosinophilic Asthma (EA) (initial): Dx of moderate to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (eg, prednisone) within the past 12 mo, or 2) Prior asthma-related hospitalization within the past 12 mo. Corticosteroid Dependent Asthma (CDA) (initial): Dx of moderate to severe asthma. Patient is currently dependent on oral corticosteroids for the treatment of asthma. EA, CDA (initial): Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications: 1) High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] and additional asthma controller medication [e.g., leukotriene receptor antagonist (eg, montelukast), long-acting beta-2 agonist (LABA) (eg, salmeterol), tiotropium] OR 2) One max-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta (fluticasone/vilanterol)). Prurigo nodularis (PN) (init): Diagnosis of PN. Trial and failure, contraindication, or intolerance to one medium or higher potency topical corticosteroid.
Age Restrictions	Asthma (initial): Patient is 6 years of age or older. AD (initial): Patient is 6 months of age or older. CRSwNP, PN: no age restriction. EoE (initial): Patient is 12 years of age or older.
Prescriber Restrictions	AD, PN (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. Asthma (init): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (initial):

	Prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CRSwNP, EoE (Init/Reauth): Plan year. Asthma, AD, PN (Init): 6 mo. Asthma, AD, PN (reauth): Plan yr.
Other Criteria	Eosinophilic esophagitis (EoE) (initial): Dx of EoE. Patient weighs at least 40 kg. Trial and failure, contraindication, or intolerance to one of the following: a) proton pump inhibitors (eg, pantoprazole, omeprazole) or b) topical (esophageal) corticosteroids (eg, budesonide, fluticasone). AD (reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Chronic rhinosinusitis with nasal polyposis (CRSwNP) (initial): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. EA (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications). CDA (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], reduction in oral corticosteroid dose). EA, CDA (reauth): Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS, 0-8 scale], improvement in nasal congestion/obstruction score [NC, 0-3 scale]). Used in combination with another agent for CRSwNP. EoE (reauth): Documentation of a positive clinical response to therapy as evidenced by improvement of at least one of the following from baseline: a) Symptoms (eg, dysphagia, chest pain, heartburn), b) Histologic measures (eg, esophageal intraepithelial eosinophil count), or c) Endoscopic measures (eg, edema, furrows, exudates, rings, strictures). PN (reauth): Documentation of a positive clinical response to therapy.

ELAHERE - UAW TRUST

Products Affected

- Elahere

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: a) epithelial ovarian cancer, b) fallopian tube cancer, or c) primary peritoneal cancer. Tumor is folate receptor-alpha (FRa) positive as detected by a U.S. Food and Drug Administration (FDA)-approved test. Disease is resistant to platinum-based chemotherapy (e.g., cisplatin, carboplatin). Patient has received one to three prior systemic treatment regimens (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ELIGARD - UAW TRUST

Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Treatment of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Prostate Cancer: Trial and failure, contraindication, or intolerance to any brand Lupron formulation. 30 mg, 45 mg: Approve for continuation of prior therapy. All other strengths: Approve for continuation of prior therapy if within the past 180 days.

ELZONRIS - UAW TRUST

Products Affected

- Elzonris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Episodic Migraines (EM) (120 mg/mL strength only) (initial): Diagnosis of EM with both of the following: 1) Less than 15 headache days per month and 2) Patient has 4 to 14 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) Topiramate (Topamax), e) Venlafaxine (Effexor), f) Candesartan (Atacand). Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. Chronic Migraines (CM) (120 mg/mL strength only) (initial): Diagnosis of CM with both of the following: 1) Greater than or equal to 15 headache days per month and 2) Greater than or equal to 8 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) OnabotulinumtoxinA (Botox), e) Topiramate (Topamax), f) Venlafaxine (Effexor), g) Candesartan (Atacand). Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. Episodic Cluster Headaches (ECH) (100 mg/mL strength only) (initial): Diagnosis of ECH. Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months. Medication will not be used in combination with another injectable CGRP inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM, CM, ECH (initial, reauth): Plan year.

Other Criteria	ECH (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another injectable CGRP inhibitor. EM, CM (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

EMPAVELI - UAW TRUST

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PNH (initial, reauth): plan year
Other Criteria	PNH (reauth): Documentation of positive clinical response to therapy (e.g., improvement in hemoglobin level, hemoglobin stabilization, decrease in the number of red blood cell transfusions).

EMPLICITI - UAW TRUST

Products Affected

- Empliciti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. One of the following: A) Both of the following: 1) Used in combination with Revlimid (lenalidomide) and dexamethasone and 2) Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)] OR B) Both of the following: 1) Used in combination with Pomalyst (pomalidomide) and dexamethasone and 2) Patient has received at least two prior therapies for multiple myeloma including lenalidomide and a proteasome inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ENBREL

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (Initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All indications (initial): 6 months, (reauth): plan year
Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR

	improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.

ENHERTU - UAW TRUST

Products Affected

- Enhertu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer (HER2-positive): Diagnosis of breast cancer. Disease is one of the following: unresectable or metastatic. Disease is human epidermal growth factor receptor 2 (HER2) -positive. Patient has received a prior anti-HER2- based regimen (e.g., trastuzumab and pertuzumab and docetaxel, ado-trastuzumab emtansine, etc.). Breast cancer (HER2-low): Diagnosis of breast cancer. Disease is one of the following: unresectable or metastatic. Disease is HER2-low. Patient has received one prior chemotherapy. Gastric cancer: Diagnosis of gastric or gastroesophageal junction (GEJ) adenocarcinoma. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Disease is one of the following: locally advanced or metastatic. Patient has received a prior trastuzumab-based regimen (e.g., Herceptin, Kanjinti). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: unresectable or metastatic. Patient has known active HER2 ERBB2 mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test. Patient has received a prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

ENJAYMO

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cold agglutinin disease (CAD) based on ALL of the following: a) Presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count), b) Positive polyspecific direct antiglobulin test (DAT), c) Monospecific DAT strongly positive for C3d, d) Cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius, and e) Direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1+ or less. Patient does not have cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders). Baseline hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL). One of the following: a) Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg, OR b) Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: Plan Year.
Other Criteria	Reauth: Documentation of a positive clinical response to therapy (e.g., the patient has not required any blood transfusions after the first 5 weeks of therapy with Enjaymo, hemoglobin level greater than or equal to 12 gram per deciliter (g/dL) or increased greater than or equal to 2 g/dL from baseline). One of the following: a) Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg, OR b) Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater.

ENSPRYNG

Products Affected

- Enspryng

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive.
Age Restrictions	N/A
Prescriber Restrictions	NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist.
Coverage Duration	NMOSD (initial, reauth): plan year
Other Criteria	NMOSD (reauth): Documentation of positive clinical response to therapy.

ENTYVIO - UAW TRUST

Products Affected

- Entyvio INJ 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ulcerative Colitis (UC) (init): Diagnosis (Dx) of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) For continuation of prior therapy if within the past 180 days. Crohn's Disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. One of the following: TF/C/I to two of the following: Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR for continuation of prior therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD (init): Prescribed or recommended by a gastroenterologist
Coverage Duration	UC, CD (init): 14 weeks. UC, CD (reauth): plan year.
Other Criteria	UC, CD (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

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	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C virus. Patient is not receiving sofosbuvir/velpatasvir in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 24 weeks. Criteria applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

EPIDIOLEX - UAW TRUST

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

EPOETIN ALFA (PREFERRED)

Products Affected

- Procrit
- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD) (Initial): Diagnosis (dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) within 30 days of request. The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. (Reauth): Diagnosis of CKD. Most recent or average (avg) Hct over 3 months is 33% or less (Hgb 11 g/dL or less) for patients on dialysis, without ESRD OR Most recent or average (avg) Hct over 3 months is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis OR Most recent or average (avg) Hct over 3 months is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Documentation of a positive clinical response to therapy from pre-treatment level. Anemia w/ HIV (Initial): Anemia by labs (Hgb less than 12 g/dL or Hct less than 36%) within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Documentation of a positive clinical response to therapy from pre-treatment level. Anemia with chemo (Initial):Other causes of anemia ruled out. Anemia with labs (Hct less than 30%, Hgb less than 10 g/dL) within prior 2 weeks of request. Cancer is non-myeloid malignancy. Patient is receiving chemo. (Reauth): Anemia by labs (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 wks of request. Documentation of a positive clinical response to therapy from pre-treatment level. Patient is receiving chemo.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD,HIV(Init):6mo.(reauth):plan yr.Chemo(init, reauth):3mo.MDS(init):3mo,(reauth):plan yr.Preop:1mo.
Other Criteria	Anemia in Myelodysplastic Syndrome (MDS) (Init): Diagnosis of MDS. Serum erythropoietin 500 mU/mL or less, or transfusion dependent MDS. (Reauth): Most recent or avg Hct over 3 months was 36% or less, OR

	most recent or avg Hgb over 3 months is 12 g/dl or less. Documentation of a positive clinical response to therapy from pre-treatment level. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following indications: Off-label uses (except Anemia in MDS and Hep C patients being treated with combo ribavirin and interferon/peginterferon): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.CKD (init, reauth), Chemo (init), preop, MDS (init): Verify Fe eval for adequate Fe stores.

ERIVEDGE - UAW TRUST

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic basal cell carcinoma (BCC): Diagnosis of metastatic basal cell carcinoma. Advanced basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma. One of the following: Cancer has recurred following surgery, Patient is not a candidate for surgery, or Patient is not a candidate for radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ERLEADA - UAW TRUST

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-metastatic castration-resistant prostate cancer (NM-CRPC): Diagnosis of non-metastatic, castration-resistant (chemical or surgical) prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin]) OR 2) Patient received a bilateral orchiectomy. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic, castration-sensitive prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron[leuprolide], Trelstar[triptorelin], etc.) OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

ERLOTINIB - UAW TRUST

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	Non-Small Cell Lung Cancer (NSCLC): 1) Diagnosis of NSCLC. Disease is one of the following: a) advanced, b) metastatic, or c) recurrent. Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletion mutations or exon 21 (L858R) substitution mutations or a known sensitizing EGFR mutation (e.g., in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation). Pancreatic cancer: Diagnosis of locally advanced, unresectable or metastatic pancreatic cancer. Used in combination with Gemzar (gemcitabine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ESBRIET

Products Affected

- Pirfenidone TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF, defined as exclusion of other known causes of interstitial lung disease and either the presence of usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF in patients not subjected to lung biopsy, or HRCT and surgical lung biopsy pattern revealing IPF or probable IPF in patients subjected to a lung biopsy. IPF (reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	(initial): Prescribed by or in consultation with a pulmonologist.
Coverage Duration	(initial, reauth): plan year
Other Criteria	N/A

EVEROLIMUS - UAW TRUST

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced Neuroendocrine Tumors (NET): Diagnosis (Dx) of neuroendocrine tumors of pancreatic origin, gastrointestinal origin, lung origin, or thymic origin. Disease is progressive. Disease is unresectable, locally advanced or metastatic. Advanced Renal Cell Carcinoma/Kidney Cancer: Dx of advanced renal cell cancer/kidney cancer. Disease is one of the following: (1) relapsed or (2) stage IV disease. Renal angiomyolipoma with tuberous sclerosis complex (TSC): Dx of renal angiomyolipoma and TSC, not requiring immediate surgery. Subependymal Giant Cell Astrocytoma (SEGA) with tuberous sclerosis (TS): Dx of SEGA associated with TS. Patient is not a candidate for curative surgical resection. Breast Cancer: Dx of recurrent or metastatic breast cancer. One of the following: Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)] OR both of the following: disease is HR- and disease has clinical characteristics that predict a HR+ tumor. Disease is HER2-negative. One of the following: Patient is a postmenopausal woman, patient is a premenopausal woman being treated with ovarian ablation/suppression, or patient is male. One of the following: A) Both of the following: a) one of the following: 1) Disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy or 2) patient was treated with tamoxifen at any time AND b) Used in combination with Aromasin (exemestane) OR B) Used in combination with Fulvestrant or Tamoxifen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	All uses: Approve for continuation of prior therapy if within the past 180 days.

EVRYSDI

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on both of the following: 1) Invasive ventilation or tracheostomy and 2) Use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Revised Upper Limb Module (RULM) Test (Non ambulatory), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Motor Function Measure 32 (MFM-32) Scale, or Item 22 of the Bayley Scales of Infant and Toddler Development Third Edition (BSID-III). Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
Age Restrictions	N/A
Prescriber Restrictions	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA
Coverage Duration	Initial, Reauth: Plan Year

Other Criteria	SMA (Reauth): Documentation of positive clinical response to therapy. Patient (pt) continues to not be dependent on both of the following: 1) Invasive ventilation or tracheostomy AND 2) use of non-invasive ventilation beyond use for naps and nighttime sleep. Pt is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) pt has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) pt has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).

EXKIVITY - UAW TRUST

Products Affected

- Exkivity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) locally advanced or b) metastatic. Disease is epidermal growth factor receptor (EGFR) exon 20 insertion mutation positive. Used as subsequent therapy for disease that has progressed on or after platinum-based chemotherapy (e.g., carboplatin, cisplatin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

FANAPT - UAW TRUST

Products Affected

- Fanapt
- Fanapt Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. Documented inadequate response or intolerance to aripiprazole and at least one other atypical antipsychotic (e.g., olanzapine, quetiapine, risperidone, ziprasidone).

FARYDAK - UAW TRUST

Products Affected

- Farydak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with one of the following: 1) Velcade (bortezomib) and dexamethasone OR 2) Kyprolis (carfilzomib) OR 3) Both of the following: Revlimid (lenalidomide) and Dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent (eg, Revlimid (lenalidomide), Thalomid (thalidomide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: a) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR b) Prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: 1) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and 2) additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) OR b) One maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)].
Age Restrictions	Initial: Patient is 12 years of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or allergy/immunology specialist
Coverage Duration	Initial: 6 mo, Reauth: Plan year
Other Criteria	Reauth: Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications). Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications.

FENTANYL (PREFERRED)

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	Cancer pain: Chart documentation provided reflecting oral transmucosal fentanyl will be used to manage pain related to an active cancer diagnosis. At least a one week history of one of the following medications to demonstrate tolerance to opioids: morphine sulfate at doses of greater than or equal to 60 mg/day, fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, oxycodone at a dose of greater than or equal to 30 mg/day , oral hydromorphone at a dose of greater than or equal to 8 mg/day, oral oxymorphone at a dose of greater than or equal to 25 mg/day, an alternative opioid at an equianalgesic dose (eg, oral methadone greater than or equal to 20 mg/day). The patient is currently taking a long-acting opioid around the clock for cancer pain
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, pain specialist, hematologist, hospice care specialist, or palliative care specialist.
Coverage Duration	Plan year
Other Criteria	N/A

FINTEPLA - UAW TRUST

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of seizures associated with Dravet syndrome, OR 2) Diagnosis of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS) (initial): Diagnosis of LEMS.
Age Restrictions	N/A
Prescriber Restrictions	LEMS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	LEMS (initial): 3 months. LEMS (reauth): Plan year.
Other Criteria	LEMS (reauth): Documentation of positive clinical response to therapy (e.g., improvement in dynamometry, Timed 25-Foot Walk Test, Timed Up and Go Test).

FLUOROURACIL - UAW TRUST

Products Affected

- Fluorouracil CREA 0.5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple actinic keratoses of the face and anterior scalp
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 30 days.
Other Criteria	N/A

FOTIVDA - UAW TRUST

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of renal cell carcinoma. Disease is one of the following: relapsed or refractory. Patient has received two or more prior systemic therapies (e.g., cabozantinib + nivolumab, lenvatinib + pembrolizumab, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

FYARRO - UAW TRUST

Products Affected

- Fyarro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Perivascular Epithelioid Cell Tumor (PEComa): Diagnosis of PEComa. Disease is one of the following: a) unresectable locally advanced or b) metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

GAMIFANT

Products Affected

- Gamifant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Hemophagocytic Lymphohistiocytosis (HLH) (initial): Diagnosis of HLH. One of the following: 1) Disease is refractory, recurrent, or progressive, or 2) Trial and failure, contraindication, or intolerance to conventional HLH therapy (e.g., etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate). HLH (initial, reauth): Patient has not received hematopoietic stem cell transplantation (HSCT).
Age Restrictions	N/A
Prescriber Restrictions	HLH (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	HLH (initial, reauth): 6 months.
Other Criteria	HLH (reauth): Documentation of positive clinical response to therapy (e.g., improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers).

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	Diagnosis of short bowel syndrome. One of the following: 1) Patient is new to Gattex therapy and is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months, or 2) Patient is currently treated with Gattex and patient has had a reduction in weekly PN/IV support from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GAVRETO - UAW TRUST

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: recurrent, advanced, or metastatic. Presence of RET (rearranged during transfection) gene fusion-positive or RET rearrangement positive tumors. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is one of the following: advanced or metastatic. Disease is rearranged during transfection (RET) gene fusion-positive. Disease requires treatment with systemic therapy. One of the following: patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

GILOTRIF - UAW TRUST

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC. One of the following: 1) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by an FDA-approved test OR 2) squamous disease progressing after previous platinum-based chemotherapy (e.g., cisplatin, carboplatin) OR 3) tumors are positive for a known sensitizing EGFR mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

GIVLAARI

Products Affected

- Givlaari

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of acute hepatic porphyria (i.e., acute intermittent porphyria, hereditary coproporphyria, variegate porphyria, ALA dehydrase deficient porphyria). Patient has active disease with at least two documented porphyria attacks within the past 6 months. Provider attestation documenting elevated urinary or plasma levels of one of the following within the past 12 months: 1) porphobilinogen (PBG) or 2) delta-aminolevulinic acid (ALA). Patient has not had a liver transplant.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist or a specialist with expertise in the diagnosis and management of acute hepatic porphyria.
Coverage Duration	Initial: 6 months. Reauth: Plan year.
Other Criteria	Reauth: Documentation of positive clinical response while on therapy as demonstrated by both of the following: 1) Reduction in hemin administration requirements and 2) Reduction in the rate or number of porphyria attacks. Patient has not had a liver transplant.

GLYCOPYRROLATE

Products Affected

- Glycopyrrolate TABS 1MG, 2MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial, Reauth: 3 months.
Other Criteria	Reauth: One of the following: 1) Patient's peptic ulcer has not healed, OR 2) Patient has a new peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine). Patient experienced a reduction in peptic ulcer symptoms while on therapy.

GRANIX - UAW TRUST

Products Affected

- Granix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, myelodysplastic syndromes (MDS)
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of neutropenia due to myelosuppressive cancer drugs for non-myeloid malignancies or use in peripheral blood progenitor cell (PBPC) collection therapy or diagnosis of myelodysplastic syndrome (MDS)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PBPC - authorization will be for 1 month. Cancer/MDS - authorization will be for 6 months.
Other Criteria	Cancer patients receiving Myelosuppressive Chemotherapy- Must meet ONE of the following - 1. be receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen) 2. be receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (e.g., at least 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, HIV infection) 3. have had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a CSF (e.g., filgrastim products, pegfilgrastin products or Leukine) and a reduced dose or frequency of chemotherapy may compromise treatment OR 4. has received chemotherapy has febrile neutropenia and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescribing physician (e.g., sepsis syndrome, older than 65 years, severe neutropenia - ANC less than 100 cells/mm3, neutropenia expected to be more than 10 days in duration, invasive fungal infection, other clinically documented infections, or prior episode of febrile neutropenia). Patients are required to try Nivestym or Zarxio prior to approval of Granix unless patient has initiated therapy

	with Granix and requires additional medication to complete the current cycle of chemotherapy.

GROWTH HORMONES

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	PGHD(initial):less than 4mo w/suspected GD based on clinical presentation (eg, persistent neonatal hypoglycemia, persistent/prolonged neonatal jaundice/elev bilirubin, male infant with microgenitalia, midline anatomical defects, failure to thrive),OR hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist

Coverage Duration	All indications (initial, reauth): Plan year
Other Criteria	AGHD(initial):dx of AGHD as a result of clin records supportng dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD,IGHDA(reauth):evidence of ongoing monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial): attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH,TSH,prolactin,FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT,glucagon,macimorelin) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, glucagon, macimorelin) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]. TPAP(reauth): evidence of positive response to therapy (eg,incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3). IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin) w/ 2 corresponding peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30,45,60,90 mins after admin].

GROWTH HORMONES (G)

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):less than 4mo w/suspected GD based on clinical presentation (eg, persistent neonatal hypoglycemia, persistent/prolonged neonatal jaundice/elev bilirubin, male infant with microgenitalia, midline anatomical defects, failure to thrive),OR hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist

Coverage Duration	All indications (initial, reauth): Plan year
Other Criteria	All(initial): Trial and failure/intolerance to Genotropin. AGHD(initial):dx of AGHD as a result of clin records supportng dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/corresp peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD,IGHDA(reauth):evidence of ongoing monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial): attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH,TSH,prolactin,FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT,glucagon,macimorelin) after d/c of tx for at least 1mo w/corresp peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, glucagon,macimorelin) after d/c of tx for at least 1mo w/corresp peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]. TPAP(reauth): evidence of positive response to therapy (eg,incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3). IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin) w/ 2 corresp peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30,45,60,90 mins after admin].

HARVONI (EM) - UAW TRUST

Products Affected

- Harvoni

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All (including patients with genotype 5 or 6 infection AND decompensated cirrhosis): A) Diagnosis of chronic hepatitis C virus, B) Patient is not receiving ledipasvir/sofosbuvir in combination with another HCV direct acting antiviral agent [eg, Sovaldi (sofosbuvir)]. ONE of the following: Trial and failure, intolerance, or contraindication (eg, safety concerns, not indicated for patient's age/weight) to a) Mavyret (except patients with decompensated cirrhosis) and b) Epclusa (brand) or sofosbuvir/velpatasvir, OR for continuation of prior ledipasvir/sofosbuvir therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

HERCEPTIN HYLECTA - UAW TRUST

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of HER2-overexpressing breast cancer. One of the following: 1) Used as adjuvant breast cancer treatment with one of the following regimens: a) administered as part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel, b) administered as part of a treatment regimen with docetaxel and carboplatin, or c) administered as a single agent following multi-modality anthracycline based therapy, OR 2) Both of the following: a) disease is metastatic and b) one of the following regimens: i) administered in combination with paclitaxel for first-line treatment, or ii) administered as a single agent for treatment in patients who have received one or more chemotherapy regimens for metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

HETLIOZ

Products Affected

- Hetlioz
- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-24-hour sleep-wake disorder: Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome). Smith-Magenis Syndrome (SMS): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
Age Restrictions	SMS: 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Non-24, SMS: 6 months
Other Criteria	Non-24: Patient is totally blind (has no light perception).

HIGH RISK MEDICATIONS - BENZODIAZEPINES - UAW TRUST

Products Affected

- Chlordiazepoxide Hcl CAPS 10MG, 5MG
- Chlordiazepoxide Hydrochloride CAPS 25MG
- Clorazepate Dipotassium TABS
- Diazepam CONC
- Diazepam INJ 50MG/10ML, 5MG/ML
- Diazepam ORAL SOLN 5MG/5ML
- Diazepam TABS
- Diazepam Intensol
- Lorazepam INJ 2MG/ML, 4MG/ML
- Lorazepam TABS
- Lorazepam Intensol
- Oxazepam
- Temazepam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Insomnia (applies to Lorazepam, Oxazepam, Temazepam): Diagnosis of insomnia. Trial and failure, contraindication or intolerance to two of the following: ramelteon, Dayvigo, Belsomra. Other indications: FDA-approved for the condition being treated or Part D medically accepted indication.
Age Restrictions	PA applies for those age 65 years and older
Prescriber Restrictions	N/A
Coverage Duration	Procedure related sedation: 1 month. All other indications: Plan Year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ANTI - PARKINSON AGENTS

Products Affected

- Benztropine Mesylate TABS
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinsonism: Diagnosis (dx) of parkinsonism. Trial and failure, contraindication, or intolerance to pramipexole and ropinirole.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ANTISPASMODICS

Products Affected

- Scopolamine PT72 1MG/3DAYS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: CYCLOBENZAPRINE

Products Affected

- Cyclobenzaprine Hydrochloride
  TABS 10MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fibromyalgia: Diagnosis of fibromyalgia. Trial and failure, contraindication, or intolerance to two of the following: pregabalin, Savella (milnacipran), and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: CYPROHEPTADINE

Products Affected

- Cyproheptadine Hcl SYRP
- Cyproheptadine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Migraine: Used for the prophylaxis of migraines. Trial and failure, contraindication, or intolerance (TF/C/I) to timolol and topiramate. Urticaria/angioedema: Diagnosis (dx) of urticaria or angioedema. TF/C/I to levocetirizine. Allergic rhinitis: Dx of allergic rhinitis. TF/C/I to levocetirizine and fluticasone. Vasomotor rhinitis: Dx of vasomotor rhinitis. TF/C/I to fluticasone.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: DIGOXIN ORAL

Products Affected

- Digitek TABS 0.25MG
- Digox TABS 250MCG
- Digoxin SOLN
- Digoxin TABS 250MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heart failure: Diagnosis (dx) of heart failure. Used in combination with ACCF/AHA guideline-directed medical therapy (GDMT). Atrial fibrillation (AF): Dx of AF. Trial and failure, contraindication, or intolerance to one of the following: 1) a beta blocker (e.g., metoprolol ER, carvedilol), 2) a nondihydropyridine calcium channel blocker (ie, verapamil, diltiazem), or 3) combination therapy with both a beta blocker and a nondihydropyridine calcium channel blocker (ie, verapamil, diltiazem).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: DIPHENOXYLATE/ATROPINE

Products Affected

- Diphenoxylate Hydrochloride/atropine Sulfate
- Diphenoxylate/atropine LIQD

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diarrhea: For use as adjunctive therapy in the management of diarrhea. Trial and failure, contraindication, or intolerance to an anti-diarrheal agent (e.g., loperamide).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: DRUGS TO AVOID IN THE ELDERLY

Products Affected

- Dipyridamole TABS
- Ergoloid Mesylates TABS
- Guanfacine Er TB24 2MG
- Guanfacine Hydrochloride TB24 1MG, 3MG, 4MG
- Ketorolac Tromethamine INJ 15MG/ML, 30MG/ML, 60MG/2ML
- Methyldopa TABS 250MG, 500MG
- Promethazine Hcl INJ
- Promethazine Hcl SUPP 12.5MG, 25MG
- Promethazine Vc
- Promethazine/phenylephrine
- Promethegan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ESTRACE - UAW TRUST

Products Affected

- Estradiol ORAL TABS 0.5MG, 1MG, 2MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance (TF/C/I) to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Osteoporosis prophylaxis: For the prevention of osteoporosis. TF/C/I to both of the following: alendronate and raloxifene. Breast cancer: Dx of breast cancer. Disease is metastatic. Used for palliative treatment. Prostatic carcinoma: Dx of advanced androgen-dependent carcinoma of the prostate. Used for palliative treatment.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ESTROGEN

Products Affected

- Amabelz
- Dotti
- Estradiol PTTW
- Estradiol PTWK
- Estradiol/norethindrone Acetate
- Lopreeza TABS 1MG; 0.5MG
- Lyllana
- Menostar
- Mimvey

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance (TF/C/I) to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Osteoporosis prophylaxis: For the prevention of osteoporosis. TF/C/I to both of the following: alendronate and raloxifene.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ESTROGEN - COMBIPATCH

Products Affected

- Combipatch

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ESTROGEN - DIVIGEL/ELESTRIN

Products Affected

- Divigel
- Estradiol GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: ETHINYL ESTRADIOL - NORETHINDRONE

Products Affected

- Fyavolv
- Jinteli
- Norethindrone Acetate/ethinyl Estradiol TABS 2.5MCG; 0.5MG, 5MCG; 1MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance (TF/C/I) to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Osteoporosis prophylaxis: For the prevention of osteoporosis. TF/C/I to both of the following: alendronate and raloxifene.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: EVAMIST

Products Affected

- Evamist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance (TF/C/I) to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: HYDROXYZINE

Products Affected

- Hydroxyzine Hcl TABS 50MG
- Hydroxyzine Hydrochloride TABS 10MG, 25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anxiety: Diagnosis (dx) of anxiety. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, buspirone, mirtazapine. Seasonal allergic rhinitis: Dx of seasonal allergic rhinitis. TF/C/I to levocetirizine and fluticasone. Pruritus: Dx of pruritus. TF/C/I to levocetirizine and topical alclometasone.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: INSOMNIA AGENTS

Products Affected

- Eszopiclone
- Zolpidem Tartrate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Insomnia: Diagnosis (dx) of insomnia. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: ramelteon, Dayvigo (lemborexant), Belsomra (suvorexant).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: MEGESTROL SUSP

Products Affected

- Megestrol Acetate SUSP 40MG/ML, 625MG/5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cancer-related cachexia: Diagnosis (dx) of cancer-related cachexia.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: MEGESTROL TAB - UAW TRUST

Products Affected

- Megestrol Acetate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cancer-related cachexia: Diagnosis (dx) of cancer-related cachexia.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: MENEST - UAW TRUST

Products Affected

- Menest

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Breast cancer: Dx of breast cancer. Disease is metastatic. Used for palliative treatment. Prostatic carcinoma: Dx of advanced prostatic carcinoma. Used for palliative treatment. Other diagnoses: Dx of one of the following: Female hypogonadism, Female castration, or Primary ovarian failure.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: NEW START HIGH RISK MEDICATION - UAW TRUST

Products Affected

- Chlordiazepoxide/amitriptyline
- Perphenazine/amitriptyline
- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG
- Phenobarbital Sodium INJ 130MG/ML, 65MG/ML
- Trimipramine Maleate 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	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, AMOXAPINE - UAW TRUST

Products Affected

- Amoxapine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, CLOMIPRAMINE - UAW TRUST

Products Affected

- Clomipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Migraine: Used for the prophylaxis of migraines. TF/C/I to timolol and topiramate. Panic disorder: Dx of panic disorder. TF/C/I to two of the following: fluoxetine, sertraline, venlafaxine. Obsessive-compulsive disorder (OCD): Dx of OCD. TF/C/I to two of the following: fluoxetine, fluvoxamine, sertraline.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, DESIPRAMINE - UAW TRUST

Products Affected

- Desipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Postherpetic neuralgia (PHN): Dx of PHN. TF/C/I to gabapentin and pregabalin. Diabetic neuropathy (DN): Dx of DN. TF/C/I to pregabalin, and venlafaxine. Interstitial cystitis: Dx of interstitial cystitis. TF/C/I to Elmiron (pentosan). Panic disorder: Dx of panic disorder. TF/C/I to two of the following: fluoxetine, sertraline, venlafaxine. Bulimia nervosa/binge eating/ eating disorder: Dx of bulimia nervosa or binge eating or eating disorder. TF/C/I to fluoxetine and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, DOXEPIN - UAW TRUST

Products Affected

- Doxepin Hcl CAPS 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 100MG, 10MG, 150MG, 25MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Pain: Dx of pain. TF/C/I to two of the following: duloxetine, etodolac, ketoprofen, and sulindac. Anxiety: Dx of anxiety. TF/C/I to two of the following: sertraline, buspirone, mirtazapine. Nicotine dependence/ smoking cessation: For treatment of nicotine dependence (smoking cessation). TF/C/I to two of the following: prescription nicotine inhaler (eg, Nicotrol), Chantix (varenicline), and bupropion. Chronic idiopathic urticaria (CIU): Dx of CIU. TF/C/I to levocetirizine and zafirlukast.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, IMIPRAMINE - UAW TRUST

Products Affected

- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Diabetic neuropathy (DN): Dx of DN. TF/C/I to pregabalin and venlafaxine. Pain: Dx of pain. TF/C/I to two of the following: duloxetine, etodolac, ketoprofen, and sulindac. Panic disorder: Dx of panic disorder. TF/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Bulimia nervosa/binge eating/ eating disorder: Dx of bulimia nerovsa or binge eating or eating disorder. TF/C/I to fluoxetine and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, NORTRIPTYLINE - UAW TRUST

Products Affected

- Nortriptyline Hcl CAPS 25MG, 75MG
- Nortriptyline Hcl SOLN
- Nortriptyline Hydrochloride CAPS 10MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Postherpetic neuralgia (PHN): Dx of PHN. TF/C/I to gabapentin and pregabalin. Diabetic neuropathy (DN): Dx of DN. TF/C/I to pregabalin and venlafaxine. Nicotine dependence/ smoking cessation: For treatment of nicotine dependence (smoking cessation). TF/C/I to two of the following: prescription nicotine inhaler (eg, Nicotrol), Chantix (varenicline), and bupropion.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PAROXETINE - UAW TRUST

Products Affected

- Paroxetine Hcl TABS 30MG, 40MG
- Paroxetine Hydrochloride SUSP
- Paroxetine Hydrochloride TABS 10MG, 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Social anxiety disorder (SAD)/social phobia: Diagnosis (dx) of SAD/social phobia. Trial and failure, contraindication, or intolerance (TF/C/I) to sertraline, and venlafaxine. Depression: Dx of depression. TF/C/I to two of the following: sertraline, bupropion, mirtazapine. Panic disorder: Dx of panic disorder. TF/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Fibromyalgia: Dx of fibromyalgia. TF/C/I to two of the following: pregabalin, Savella (milnacipran), fluvoxamine. Obsessive-compulsive disorder (OCD): Dx of OCD. TF/C/I to two of the following: fluoxetine, fluvoxamine, sertraline. General anxiety disorder (GAD): Dx of GAD. TF/C/I to two of the following: sertraline, buspirone, mirtazapine. Post-traumatic stress disorder (PTSD): Dx of PTSD. TF/C/I to fluvoxamine and sertraline.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PAROXETINE ER - UAW TRUST

Products Affected

- Paroxetine Hcl Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Social anxiety disorder (SAD)/social phobia: Diagnosis (dx) of SAD/social phobia. Trial and failure, contraindication, or intolerance (TF/C/I) to sertraline and venlafaxine. Depression: Dx of depression. TF/C/I to two of the following: sertraline, bupropion, mirtazapine. Panic disorder: Dx of panic disorder. TF/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Fibromyalgia: Dx of fibromyalgia. TF/C/I to two of the following: pregabalin, Savella (milnacipran), fluvoxamine. Hot flashes/night sweats: Dx of hot flashes/night sweats. TF/C/I to fluoxetine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PROTRIPTYLINE - UAW TRUST

Products Affected

- Protriptyline Hcl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: sertraline, bupropion, mirtazapine. Migraine: Used for the prophylaxis of migraines. TF/C/I to timolol and topiramate.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: PREMARIN - UAW TRUST

Products Affected

- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance (TF/C/I) to both of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Osteoporosis prophylaxis: For the prevention of osteoporosis. TF/C/I to both of the following: alendronate and raloxifene. Breast cancer: Dx of breast cancer. Disease is metastatic. Used for palliative treatment. Prostatic carcinoma: Dx of advanced androgen-dependent carcinoma of the prostate. Used for palliative treatment.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: PROMETHAZINE ORAL

Products Affected

- Promethazine Hcl TABS 12.5MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 25MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urticaria: Diagnosis (dx) of urticaria. Trial and failure, contraindication, or intolerance (TF/C/I) to levocetirizine. Angioedema: Dx of angioedema. Allergic rhinitis: Dx of allergic rhinitis. TF/C/I to levocetirizine and fluticasone. Vasomotor rhinitis: Dx of vasomotor rhinitis. TF/C/I to fluticasone. Nausea/vomiting (N/V): a) Treatment of postoperative N/V, or b) Treatment of N/V due to labor, or c) Treatment of N/V associated with motion sickness.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs D review. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HRM: SKELETAL MUSCLE RELAXANTS

Products Affected

- Chlorzoxazone TABS 500MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute, painful musculoskeletal conditions: Diagnosis (dx) of an acute, painful, musculoskeletal condition.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population. Approve for continuation of prior therapy if within the past 180 days.

HUMIRA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): Diagnosis (Dx) of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate (MTX), leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): Dx of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA)(Initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (PSO)(Initial): Dx of moderate to severe chronic PSO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week TF/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS)(Initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD)(Initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine (6-MP), azathioprine, corticosteroid (eg, prednisone), MTX. Uveitis(Initial): Dx of non-infectious uveitis classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, JIA: (Initial) Prescribed by or in consultation with a rheumatologist. PsA: (Initial) Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS: (Initial) Prescribed by or in consultation with a dermatologist. CD, UC: (Initial) Prescribed

	by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with a rheumatologist or an ophthalmologist.
Coverage Duration	UC: (Initial) 12 wks. Other uses (initial): 6 months. All uses (reauth): plan year.
Other Criteria	Ulcerative Colitis (UC) (Initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-MP, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Hidradenitis suppurativa (HS) (Initial): Dx of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Documentation of positive clinical response to therapy. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation

	rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

HYDROXYPROGESTERONE - UAW TRUST

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amenorrhea/Abnormal Uterine Bleeding: Diagnosis of one of the following: 1) primary or secondary amenorrhea or 2) abnormal uterine bleeding. Amenorrhea or abnormal uterine bleeding is due to hormonal imbalance in the absence of organic pathology (eg, submucous fibroids or uterine cancer). Endometrial disorder: Used for production of secretory endometrium and desquamation. Uterine cancer: Diagnosis of Stage III or IV adenocarcinoma of the uterine corpus. Estrogen testing: Used for the testing of endogenous estrogen production. All indications: Patient is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	Uterine cancer: Prescribed by or in consultation with an oncologist.
Coverage Duration	Amenorrhea/Abnormal Uterine Bleeding: 4 mo. Estrogen testing: 2 mo. All other uses: plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IBRANCE - UAW TRUST

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is a) locally advanced, metastatic, recurrent, or Stage IV
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ICATIBANT

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE: Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Plan year
Other Criteria	N/A

ICLUSIG - UAW TRUST

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous / Myeloid Leukemia (CML): Diagnosis of chronic myelogenous/myeloid leukemia (CML). One of the following: a) Both of the following: Disease is in the chronic phase AND patient is unable to take or has failed treatment with two or more alternative tyrosine kinase inhibitors (TKI) [eg, Bosulif (bosutinib), imatinib, Sprycel (dasatinib), Tasigna (nilotinib)], b) confirmed documentation of T315I mutation, or c) Both of the following: Disease is in the accelerated or blast phase AND no other kinase inhibitors are indicated. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL). One of the following: a) No other kinase inhibitors are indicated, b) Confirmed documentation of T315I mutation, c) Disease is relapsed or refractory, d) Used as a component of HyperCVAD regimen (hyper-fractionated cyclophosphamide, vincristine, doxorubicin, and dexamethasone, alternating with high-dose methotrexate and cytarabine) induction or consolidation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IDHIFA - UAW TRUST

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. AML is isocitrate dehydrogenase-2 (IDH2) mutation-positive. One of the following: A) Disease is relapsed or refractory OR B) Both of the following: Patient is 60 years of age or older AND one of the following: 1) Patient is not a candidate for or patient declines intensive induction therapy or 2) Used for post induction therapy following response to low intensity induction therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IGALMI - UAW TRUST

Products Affected

- Igalmi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: Schizophrenia or Bipolar I or II disorder. For the treatment of acute agitation. Trial and failure, contraindication or intolerance to at least two products used in acute agitation (e.g., olanzapine, ziprasidone). Patient is currently being managed with maintenance medication for their underlying disorder (e.g., aripiprazole, olanzapine, quetiapine, lithium, valproic acid).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	For continuation of prior therapy if within the past 180 days.

ILARIS

Products Affected

- Ilaris INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Periodic Fever Syndromes (Initial): Diagnosis (dx) of one of the following Periodic Fever Syndromes: Cryopyrin-Associated Period Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever (FMF). Dx of CAPS confirmed by NRLP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation or evidence of active inflammation including both of the following: clinical symptoms (eg, rash, fever, arthralgia) and elevated acute phase reactants (eg, ESR, CRP). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial)): Dx of active SJIA (eg, fever, serositis, rash, arthritis). Still's Disease (Initial): Diagnosis of Still’s Disease, including Adult-Onset Still’s Disease (AOSD).
Age Restrictions	N/A
Prescriber Restrictions	Periodic Fever Syndrome (initial): Prescribed by or in consultation with an allergist/immunologist, dermatologist, or rheumatologist. SJIA, Still's Disease (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All uses (initial): 6 months, (reauth): plan year
Other Criteria	SJIA, Still's Disease (initial): Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a non-steroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic corticosteroid (eg, prednisone). Periodic Fever Syndromes, Still's Disease (Reauth): Documentation of positive clinical response to therapy. SJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from

	baseline, OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline.

IMATINIB - UAW TRUST

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of CML (CML). Acute Lymphoblastic Leukemia (ALL): Diagnosis of Philadelphia chromosome positive/BCR ABL-positive ALL (Ph+/BCR ABL+ ALL). Myelodysplastic/ myeloproliferative disease (MDS/MPD): Diagnosis of MDS/MPD. One of the following: 1) Disease is associated with 5q32 translocations or 2) Disease is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements or 3) disease is associated with a t(5:12) translocation associated with the ETV6-PDGFRbeta fusion gene. Aggressive systemic mastocytosis (ASM): Diagnosis of ASM. Patient is without the D816V c-Kit mutation or c-Kit mutational status unknown or eosinophilia is present with FIP1L1-PDGFRA fusion gene. Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL): Diagnosis of at least one of the following: HES or CEL. Dermatofibrosarcoma protuberans (DFSP): Diagnosis of DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IMBRUVICA - UAW TRUST

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Chronic Graft Versus Host Disease (cGVHD): Diagnosis of cGVHD AND trial and failure of at least one other systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IMFINZI - UAW TRUST

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): 1) Diagnosis of NSCLC AND 2) One of the following: a) All of the following: i) Disease is stage III, ii) unresectable, AND iii) Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy OR b) All of the following: i) Disease is metastatic, ii) Used in combination with Imjudo (tremelimumab-actl) and platinum-based chemotherapy (e.g., carboplatin, cisplatin), and iii) Disease has no sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) genomic tumor aberrations. Small Cell Lung Cancer: 1) Diagnosis of extensive-stage small cell lung cancer (ES-SCLC) AND 2) Used as first line treatment AND 3) Both of the following: a) Used in combination with Etoposide and b) Used in combination with carboplatin or cisplatin. Biliary Tract Cancer (BTC): 1) Diagnosis of biliary tract cancer AND 2) Disease is one of the following: a) Locally advanced OR b) Metastatic AND 3) Used in combination with gemcitabine and cisplatin. Hepatocellular Carcinoma (HC): Diagnosis of unresectable hepatocellular carcinoma (uHCC). Used in combination with Imjudo (tremelimumab-actl).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IMJUDO - UAW TRUST

Products Affected

- Imjudo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hepatocellular Carcinoma: Diagnosis of unresectable hepatocellular carcinoma (uHCC). Used in combination with Imfinzi (durvalumab). Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Used in combination with Imfinzi (durvalumab) and platinum-based chemotherapy (e.g., carboplatin, cisplatin). Disease has no sensitizing epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IMMUNE GLOBULIN

Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam
- Panzyga
- Privigen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary immunodeficiency syndrome (PIS): patients with PIS. Idiopathic Thrombocytopenic Purpura (ITP): diagnosis (dx) of ITP. Documented (doc) platelet count of less than 50 x 10^9/L. Kawasaki disease (KD): dx of KD. B-cell Chronic Lymphocytic Leukemia (CLL): dx of B-Cell CLL. Doc hypogammaglobulinemia (IgG less than 500mg/dL) or history of bacterial infections associated with B-cell CLL. Bone Marrow Transplant (BMT): Confirmed allogeneic BMT within the last 100 days. Doc severe hypogammaglobulinemia (IgG less than 400 mg/dL). HIV:dx of HIV. 13 years of age or less. Doc hypogammaglobulinemia (IgG less than 400 mg/dL) or functional antibody deficiency demonstrated by poor specific antibody titers or recurrent bacterial infections. Guillain-Barre Syndrome (GBS) initial: dx of GBS. severe disease requiring aid to walk. Onset of neuropathic symptoms in the last 4 weeks. Myasthenia Gravis (MG): dx of generalized MG. Evidence of myasthenic exacerbation, defined by 1 of the following sxs in the last month: difficulty swallowing, acute respiratory failure, or major functional disability responsible for the discontinuation of physical activity. Concomitant immunomodulator therapy (tx)(eg, azathioprine, cyclosporine), unless contraindicated, will be used for long-term management of MG. Dermatomyositis and Polymyositis (D/P) initial: dx of dermatomyositis or polymyositis. Trial and failure, contraindication or intolerance (TF/C/I) to immunosuppressive tx (eg corticosteroids, methotrexate, azathioprine, cyclophosphamide). Stiff person syndrome (SPS) initial:dx of SPS. TF/C/I to GABAergic medication (eg, baclofen). TF/C/I to immunosuppressive tx (eg, azathioprine, corticosteroids). Lambert-Eaton myasthenic syndrome (LEMS) initial: dx of LEMS. TF/C/I to immunomodulator monotherapy (eg, azathioprine, corticosteroids). Concomitant immunomodulator tx (eg, azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS.
Age Restrictions	N/A
Prescriber Restrictions	MG: Prescribed by a neurologist.

Coverage Duration	KD: 1 mo. GBS,CIDP (initial), MG: 3 mo. ITP: 6 mo. CIDP,GBS (reauth), other uses: plan year.
Other Criteria	Subject to Part B vs. Part D review. PIS: Clinically significant functional deficiency of humoral immunity as evidenced by doc failure to produce antibodies to specific antigens or hx of significant recurrent infxns. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) initial: dx of CIDP confirmed by: (1) progressive sxs present for at least 2 mo, (2) symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor impairment of more than 1 limb, OR Progressive or relapsing sensory impairment of more than 1 limb, (3) Electrophysiologic findings when 3 of the following 4 criteria are present: Partial conduction block of 1 or more motor nerve, Reduced conduction velocity of 2 or more motor nerves, Prolonged distal latency of 2 or more motor nerves, Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves. Multifocal motor neuropathy (MMN) initial: dx of MMN as confirmed by all of the following: (1) weakness with slowly progressive or stepwise progressive course over at least 1 month, (2) asymmetric involvement of 2 or more nerves, AND (3) absence of motor neuron signs and bulbar signs. CIDP, MMN reauth: documentation of positive clinical response to tx as measured by an objective scale [eg, Rankin, Modified Rankin, Medical Research Council (MRC) scale]. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect. Relapsing remitting Multiple Sclerosis (MS) initial: dx of relapsing remitting form of MS (RRMS). Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin tx. TF/c/I to 2 of the following: Aubagio (teriflunomide),Betaseron (interferon beta-1b), Avonex (interferon beta-1a), Copaxone (glatiramer acetate),Rebif (interferon beta-1a), Tysabri (natalizumab), Tecfidera (dimethyl fumarate), Extavia (interferon beta-1b), Gilenya (Fingolimod). RRMS reauth: The prescriber maintains and provides chart documentation of the patient's evaluation, including all of the following: findings of interval examination including neurological deficits incurred, and assessment of disability (eg, Expanded Disability Status Score [EDSS], Functional Systems Score [FSS], Multiple Sclerosis Functional Composite [MSFC], Disease Steps [DS]). Stable or improved disability score (eg, EDSS, FSS, MSFC, DS). Documentation of decreased number of relapses since starting immune globulin tx. Dx continues to be the relapsing-remitting form of MS. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect. GBS, D/P, SPS, LEMS reauth: Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect.

IMMUNE GLOBULIN (SCIG)

Products Affected

- Hizentra
- Hyqvia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary immunodeficiency syndrome (PIS): Patients with PIS. Clinically significant functional deficiency of humoral immunity as evidenced by one of the following: a) Documented failure to produce antibodies to specific antigens, b) History of significant recurrent infections. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) initial: dx of CIDP confirmed by: (1) progressive sxs present for at least 2 mo, (2) symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor impairment of more than 1 limb, OR Progressive or relapsing sensory impairment of more than 1 limb, (3) Electrophysiologic findings when 3 of the following 4 criteria are present: Partial conduction block of 1 or more motor nerve, Reduced conduction velocity of 2 or more motor nerves, Prolonged distal latency of 2 or more motor nerves, Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PIS: Plan Year. CIDP (initial) 3 mo. CIDP (reauth) Plan Year
Other Criteria	Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. CIDP (reauth): 1) Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale] and 2) Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect.

INFLIXIMAB PREFERRED

Products Affected

- Inflectra
- Remicade
- Renflexis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. CD, FCD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. Sarcoidosis: Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.

Coverage Duration	All indications (initial): 6 months, (reauth): plan year
Other Criteria	Ankylosing Spondylitis (AS) (initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (initial): Dx of sarcoidosis. TF/C/I to both of the following: immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine) AND corticosteroid (eg, prednisone). CD, UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. RA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. Sarcoidosis (Reauth): Documentation of positive clinical response to therapy.

INJECTABLE TESTOSTERONE - UAW TRUST

Products Affected

- Testosterone Cypionate INJ 100MG/ML, 200MG/ML
- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum testosterone level or calculated free or bioavailable testosterone level within or below the normal limits of the reporting lab, or ii) Follow-up total serum testosterone level or calculated free or bioavailable testosterone level outside of upper limits of normal for the reporting lab and the dose is adjusted. (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/gender incongruence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year.
Other Criteria	N/A

INLYTA - UAW TRUST

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced Renal Cell Carcinoma: Diagnosis of renal cell cancer. One of the following: (1) disease has relapsed, (2) diagnosis of stage IV disease, or (3) Both of the following: a) Disease is advanced, and b) One of the following: i) Patient has failed one prior systemic therapy (e.g., chemotherapy), or ii) Inlyta will be used in combination with Bavencio (avelumab) or Keytruda (pembrolizumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

INQOVI - UAW TRUST

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Both of the following: a) Diagnosis of myelodysplastic syndrome (MDS) and b) Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS), OR 2) Diagnosis of chronic myelomonocytic leukemia (CMML).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

INREBIC - UAW TRUST

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

INTRON - A - UAW TRUST

Products Affected

- Intron A

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Diagnosis of chronic hepatitis C, patient without decompensated liver disease, patients who have not previously been treated with interferon, and one of the following - 1) used in combination with ribavirin or 2) contraindication or intolerance to ribavirin. Metastatic renal cell carcinoma (RCC): diagnosis of metastatic RCC, used in combination with Avastin (bevacizumab). Other: diagnosis of condylomata acuminata (genital or perianal), diagnosis of hairy cell leukemia, diagnosis of AIDS-related Kaposi's sarcoma, diagnosis of malignant melanoma, diagnosis of Stage III or IV follicular Non-Hodgkin's Lymphoma.
Age Restrictions	N/A
Prescriber Restrictions	RCC: Prescribed by or in consultation with an oncologist.
Coverage Duration	HepB, HepC: 48 wks. Condylomata acuminata (genital or perianal): 6 wks. Other: 12 months
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

IRESSA - UAW TRUST

Products Affected

- Gefitinib
- Iressa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC, and One of the following: tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions or tumors are positive for EGFR exon 21 (L858R) substitution mutations or tumors are positive for a known sensitizing EGFR mutation (e.g., in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ISTURISA

Products Affected

- Isturisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Patient is not a candidate for pituitary surgery, OR b) Pituitary surgery has not been curative for the patient.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's disease (initial, reauth): Plan Year
Other Criteria	Cushing's disease (reauth): Documentation of positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).

ITRACONAZOLE (CAPSULES)

Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infections: Diagnosis of blastomycosis, histoplasmosis, or aspergillosis. Onychomycosis: Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Systemic Fungal infxns: plan year. Onychomycosis: (Fingernail) 2 mo. (Toenail) 3 mo.
Other Criteria	N/A

ITRACONAZOLE (SOLUTION)

Products Affected

- Itraconazole SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fungal Infections: Diagnosis of oropharyngeal or esophageal candidiasis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

IVERMECTIN TABLETS

Products Affected

- Ivermectin TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Any medically accepted indication [e.g., Onchocerciasis due to nematode parasite, Pediculosis, Strongyloidiasis, Ascariasis, Scabies (including crusted scabies), Cutaneous larva migrans (hook worm disease), Enterobiasis, Filariasis, Trichuriasis, or Gnathostomiasis].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

JAKAFI - UAW TRUST

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: One of the following: Primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera and trial and failure, contraindication, or intolerance to one of the following: hydroxyurea or interferon therapy (e.g., Intron A, pegasys, etc.). Graft versus host disease (GVHD): Diagnosis of GVHD. Disease is steroid-refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

JAYPIRCA - UAW TRUST

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL). Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior systemic therapies [e.g., chemotherapy] for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Imbruvica (ibrutinib), Calquence (acalabrutinib), Brukinsa (zanubrutinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

JEMPERLI - UAW TRUST

Products Affected

- Jemperli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Endometrial Cancer: Diagnosis of endometrial cancer. Disease is one of the following: a) advanced or b) recurrent. Disease is mismatch repair deficient (dMMR) as detected by a U.S. Food and Drug Administration (FDA)-approved test. Patient has progressed on or following prior treatment with a platinum-containing regimen (e.g., carboplatin, cisplatin). Solid Tumors: Diagnosis of solid tumor. Disease is one of the following: a) advanced or b) recurrent. Disease is mismatch repair deficient (dMMR) as detected by a U.S. Food and Drug Administration (FDA)-approved test. Patient has progressed on or following prior treatment. Patient does not have satisfactory alternative treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

JUXTAPID

Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated/pre-treatment LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. One of the following: a) patient is receiving other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Trial and failure, contraindication, or intolerance to Repatha therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): plan year
Other Criteria	HoFH (reauthorization): One of the following: a) patient continues to receive other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Submission of medical records (eg, chart notes, laboratory values) documenting LDL-C reduction from baseline while on therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

JYNARQUE

Products Affected

- Jynarque

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Autosomal dominant polycystic kidney disease (ADPKD) (initial): Diagnosis of rapidly progressing ADPKD. One of the following: 1) Both of the following: A) Patient has received Jynarque for less than or equal to 18 months AND B) Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: A) Patient has received Jynarque for longer than 18 months AND B) ALT, AST, and bilirubin will be measured at least every 3 months. Patient does not have a history of significant liver impairment or injury, not including uncomplicated polycystic liver disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	ADPKD (reauth): Documentation of positive clinical response to therapy. Patient does not have signs or symptoms consistent with hepatic injury, not including uncomplicated polycystic liver disease. One of the following: 1) Both of the following: A) Patient has received Jynarque for less than or equal to 18 months AND B) Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: A) Patient has received Jynarque for longer than 18 months AND B) ALT, AST, and bilirubin will be measured at least every 3 months.

KADCYLA - UAW TRUST

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Early breast cancer (EBC): Diagnosis of HER2-positive early breast cancer. Metastatic breast cancer (MBC): Diagnosis of HER2-positive metastatic breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Submission of laboratory records confirming patient has at least one mutation in the CFTR gene that is responsive to ivacaftor potentiation.
Age Restrictions	CF (initial): Patient is 1 month of age or older.
Prescriber Restrictions	CF (initial, reauth): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial): 6 mos, (reauth): plan year
Other Criteria	CF (reauth): Documentation of one of the following while on therapy: Improved lung function or stable lung function.

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	Initial: Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D). Urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g. Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2. One of the following: 1) Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following: a) generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: Plan year
Other Criteria	Reauth: Documentation of positive clinical response to therapy. One of the following: 1) Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB, OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs.

KEYTRUDA - UAW TRUST

Products Affected

- Keytruda INJ 100MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

KIMMTRAK - UAW TRUST

Products Affected

- Kimmtrak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of uveal melanoma. Disease is unresectable or metastatic. Patient is HLA-A*02:01 genotype positive as determined by a high-resolution genotyping test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

KINERET - UAW TRUST

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID. Dx of NOMID confirmed by one of the following: 1) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3-gene) (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation or 2) Both of the following: a) two of the following clinical symptoms: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia), chronic aseptic meningitis, or skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing) AND b) elevated acute phase reactants (eg, erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA]). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with an allergist/immunologist, pediatrician, or rheumatologist.
Coverage Duration	RA, NOMID (initial): 6 months, (reauth): plan year. DIRA: plan year.
Other Criteria	RA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (Reauth): Documentation of positive clinical response to therapy.

KISQALI - FEMARA PACK - UAW TRUST

Products Affected

- 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	Breast cancer: Diagnosis of advanced, recurrent, or metastatic breast cancer. Cancer is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

KISQALI - UAW TRUST

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of advanced, recurrent, or metastatic breast cancer. Cancer is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative. One of the following: A) Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or B) Used in combination with Faslodex (fulvestrant).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	(Initial): Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant. (Reauthorization): Documentation of one of the following: patient has improved glucose tolerance while on therapy or patient has stable glucose tolerance while on therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

KOSELUGO - UAW TRUST

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment, bladder/bowel dysfunction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

KRAZATI - UAW TRUST

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Presence of KRAS G12C mutation. Disease is recurrent, advanced, or metastatic. Patient has received at least one prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

KRYSTEXXA

Products Affected

- Krystexxa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gout (initial): Diagnosis of gout. Trial, failure, contraindication or intolerance to both of the following: allopurinol and febuxostat.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Gout (initial): 6 months. Reauth: Plan Year
Other Criteria	Gout (reauth): Documentation of a positive clinical response to therapy

KYNMOBI

Products Affected

- Kynmobi
- Kynmobi Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not used with any 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron).
Required Medical Information	Parkinson's disease (PD): Diagnosis of PD. Unable to control off symptoms with one conventional oral therapy [e.g., Comtan (entacapone), Mirapex (pramipexole), Requip (ropinirole), Sinemet (carbidopa/levodopa), Stalevo (carbidopa/levodopa/entacapone), amantadine, Tasmar (tolcapone)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KYPROLIS - UAW TRUST

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma. Disease is relapsed or refractory. Patient has received at least one prior therapy for multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

LAMPIT

Products Affected

- Lampit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chagas disease: Diagnosis of Chagas disease (American Trypanosomiasis), caused by Trypanosoma cruzi.
Age Restrictions	Chagas disease: Patient is pediatric patient (birth to less than 18 years of age and weighing at least 2.5 kg)
Prescriber Restrictions	N/A
Coverage Duration	60 days
Other Criteria	N/A

LAPATINIB - UAW TRUST

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	Breast Cancer: One of the following: A) Diagnosis of recurrent or stage IV hormone receptor positive (HR+), human epidermal growth factor receptor 2-positive (HER2+) breast cancer. Used in combination with an aromatase inhibitor [eg, Aromasin (exemestane), Femara (letrozole), Arimedex (anastrozole)]. OR B) Diagnosis of recurrent or metastatic HER2+ breast cancer. Used in combination with trastuzumab or Xeloda (capecitabine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LEMTRADA

Products Affected

- Lemtrada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Patient has not been previously treated with alemtuzumab, and failure after a trial of at least 4 weeks, contraindication, or intolerance to two of the following disease-modifying therapies for MS: A) Aubagio (teriflunomide), B) Mavenclad (cladribine), C) Plegridy (peginterferon beta-1a), D) Tysabri (natalizumab), E) Any one of the interferon beta-1a injections (eg, Avonex), F) Any one of the interferon beta-1b injections (eg, Betaseron, Extavia), G) Any one of the oral fumarates (eg, brand Tecfidera, generic dimethyl fumarate), H) Any one of the glatiramer acetate injections (eg, Copaxone, Glatopa, generic glatiramer acetate), I) Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (eg, Gilenya [fingolimod], Mayzent [siponimod], Zeposia [ozanimod]), J) Any one of the B-cell targeted therapies (eg, Ocrevus [ocrelizumab], Kesimpta [ofatumumab]), or 2) Patient has previously received treatment with alemtuzumab, and at least 12 months have or will have elapsed since the most recent treatment course with alemtuzumab. Not used in combination with another disease-modifying therapy for MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MS: Plan year
Other Criteria	N/A

LENVIMA - UAW TRUST

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	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Renal cell carcinoma: Diagnosis of Advanced Renal cell carcinoma. Hepatocellular Carcinoma (HCC): Diagnosis of Hepatocellular Carcinoma or liver cell carcinoma. Endometrial Carcinoma: Diagnosis of advanced endometrial carcinoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bone Marrow/Stem Cell Transplant (BMSCT): Patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT), OR used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR both of the following: patient has had a peripheral stem cell transplant (PSCT) and patient has received myeloablative chemotherapy. Acute myeloid leukemia (AML): Diagnosis of AML. Patient has completed induction or consolidation chemotherapy. Neutropenia Associated Dose Dense Chemotherapy (NDDC): Patient is receiving NCI's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, or a dose-dense regimen for which the incidence of febrile neutropenia is unknown. Chemotherapy-Induced Febrile Neutropenia (CFN): Patient is receiving a chemotherapy regimen associated with greater than 20% incidence of febrile neutropenia, or patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has 1 or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. Secondary prophylaxis of FN (SPFN): For patients who are receiving myelosuppressive anticancer drugs associated with neutropenia. Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of Febrile Neutropenia (FN): Patient has received or is receiving a myelosuppressive anticancer drug associated with neutropenia. Diagnosis of febrile neutropenia. Patient is at high risk for infection-associated complications. HIV-Related Neutropenia (HIVN): Diagnosis of HIV infection. ANC less than or equal to 1,000 cells/mm3. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	AML: greater than or equal to 55 years old.
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist except HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist.

Coverage Duration	BMSCT,NDDC,CFN,SPFN, AML, FN: 3mo or duration of tx. HIVN: 6mo. ARS: 1mo.
Other Criteria	N/A

LEUPROLIDE ACETATE - UAW TRUST

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Treatment of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate Cancer: plan year
Other Criteria	Prostate Cancer: Approve for continuation of prior therapy if within the past 180 days.

LIBTAYO - UAW TRUST

Products Affected

- Libtayo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous Squamous Cell Carcinoma (CSCC): Diagnosis of CSCC. Disease is metastatic or locally advanced. Patient is not a candidate for curative surgery or curative radiation. Basal Cell Carcinoma (BCC): Diagnosis of BCC. Disease is locally advanced or metastatic. One of the following: a) Patient has been previously treated with a hedgehog pathway inhibitor (e.g., Erivedge, Odomzo, Daurismo), or b) Provider attests that a hedgehog pathway inhibitor is not appropriate. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. One of the following: a) Patient's disease has high PD-L1 expression [Tumor Proportion Score (TPS) greater than or equal to 50%] with no EGFR, ALK or ROS1 aberrations as determined by a U.S. Food and Drug Administration (FDA)-approved test, or b) Both of the following: i) Used in combination with platinum-based chemotherapy (e.g., carboplatin, cisplatin), and ii) Patient's disease has no EGFR, ALK, or ROS1 aberrations. Disease is one of the following: a) metastatic or b) locally advanced where patients are not candidates for surgical resection or definitive chemoradiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LIDOCAINE PATCH

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
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	Diagnosis of cytomegalovirus (CMV) infection/disease. Patient is a recipient of one of the following: a) Hematopoietic stem cell transplant OR b) Solid organ transplant. Trial and failure of a minimum 2 weeks duration, contraindication, or intolerance to one of the following therapies at an appropriately indicated dose: a) Intravenous (IV) ganciclovir, b) Oral valganciclovir, c) IV foscarnet, OR d) IV cidofovir. Patient weighs greater than or equal to 35 kg.
Age Restrictions	Patient is 12 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a provider who specializes in one of the following areas: transplant or infectious disease.
Coverage Duration	8 weeks
Other Criteria	N/A

LONG ACTING OPIOIDS - UAW TRUST

Products Affected

- Buprenorphine PTWK
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadone Hydrochloride CONC
- Methadone Hydrochloride Intensol
- Methadose CONC 10MG/ML
- Methadose Sugar-free
- Morphine Sulfate Er CP24
- Morphine Sulfate Er TBCR
- Oxymorphone Hydrochloride Er TB12 10MG, 15MG, 20MG, 30MG, 5MG, 7.5MG
- Oxymorphone Hydrochlorideer

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Acute (i.e., non-chronic) pain
Required Medical Information	Chronic pain: Diagnosis of chronic pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patients history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (i.e., FDA labeled use) prior to reviewing for quantity exception.

LONSURF - UAW TRUST

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Trial and failure, contraindication, or intolerance with all of the following: fluoropyrimidine-based chemotherapy, oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF biological therapy (e.g., bevacizumab). One of the following: a) tumor is RAS mutant-type or b) tumor is RAS wild-type and Trial and failure, contraindication or intolerance to one anti-EGFR therapy (eg, Vectibix [panitumumab], Erbitux [cetuximab]). Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Trial and failure, contraindication or intolerance to at least two of the following: fluropyrimidine-based chemotherapy (e.g. fluorouracil), Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LORBRENA - UAW TRUST

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. One of the following: A) Disease is advanced, metastatic, or recurrent and anaplastic lymphoma kinase (ALK)-positive OR B) Both of the following: 1) Disease is both of the following: i) advanced, metastatic, or recurrent and ii) ROS proto-oncogene 1 (ROS1)-positive AND 2) Disease has progressed on at least one of the following therapies: Xalkori (crizotinib), Rozlytrek (entrectinib), or Zykadia (ceritinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LUMAKRAS - UAW TRUST

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) recurrent, b) advanced or c) metastatic. Tumor is KRAS G12C-mutated. Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LUMOXITI - UAW TRUST

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hairy Cell Leukemia: Diagnosis of hairy cell leukemia (HCL). Disease is relapsed or refractory. Patient has received at least two prior systemic therapies, including treatment with a purine nucleoside analog
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

LUPRON DEPOT - UAW TRUST

Products Affected

- 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	Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Treatment of advanced prostate cancer. Endometriosis (3.75 mg, 11.25 mg) (initial): Diagnosis of endometriosis. One of the following: a) Patient has had surgical ablation to prevent recurrence, or b) trial and failure, contraindication, or intolerance to one NSAID (e.g., diclofenac, ibuprofen, meloxicam, naproxen) and one oral contraceptive (e.g., norethindrone-ethinyl estradiol, estradiol and norethindrone). Endometriosis (3.75 mg, 11.25 mg) (reauthorization): Symptoms recur after one course. Used in combination with one of the following: norethindrone 5 mg daily, other "add -back" sex hormones (e.g., estrogen, medroxyprogesterone), or other bone-sparing agents (e.g., bisphosphonates). Uterine Leiomyomata (3.75 mg, 11.25 mg) (fibroids): Either for use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) Or all of the following: treatment of anemia, anemia caused by uterine leiomyomata (fibroids), and use prior to surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: plan yr. Endometrosis(all), Uterine leiomyomata (anemia): 6 mo. (fibroids): 4 mo.
Other Criteria	Prostate Cancer (7.5 mg, 22.5 mg): Approve for continuation of prior therapy if within the past 180 days. Prostate Cancer (30 mg, 45 mg): Approve for continuation of prior therapy.

LUPRON DEPOT PED

Products Affected

- Lupron Depot-ped INJ 45MG
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): diagnosis of central precocious puberty (idiopathic or neurogenic). Onset of secondary sexual characteristics in one of the following: females less than age 8 or males less than age 9. Confirmation of diagnosis defined by one of the following: pubertal basal level of luteinizing hormone (based on laboratory reference ranges), a pubertal response to a GnRH stimulation test, or bone age advanced one year beyond the chronological age.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CPP (initial, reauth): plan year
Other Criteria	CPP (reauth): Documentation of bone age monitoring (eg, radiographic imaging).

LYNPARZA - UAW TRUST

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	High risk early breast cancer: Diagnosis of high risk early breast cancer. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease is human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) Disease is hormone receptor (HR)-negative, OR b) Both of the following: i) Disease is HR-positive AND ii) Patient is continuing concurrent treatment with endocrine therapy. Patient has been previously treated with neoadjuvant or adjuvant chemotherapy (e.g., anthracycline, taxane). Metastatic or recurrent breast cancer: Diagnosis of breast cancer. Disease is metastatic or recurrent. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease is human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) Disease is hormone receptor (HR) negative, or b) Disease is hormone receptor (HR)-positive and one of the following: i) disease has progressed on previous endocrine therapy or ii) provider attestation that treatment with endocrine therapy is inappropriate for the patient's disease. Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Disease is metastatic. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease has not progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen (e.g., FOLFIRINOX, FOLFOX, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Ovarian cancer (Maintenance Therapy): Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Disease is one of the following: advanced or recurrent. One of the following: 1) Patient has had a complete or partial response to platinum-based chemotherapy (e.g., carboplatin, cisplatin), or 2) Both of the following: a) patient has had a complete or partial response to first-line platinum-based chemotherapy (e.g., carboplatin, cisplatin) AND b)

	one of the following: i) presence of deleterious or suspected deleterious germline or somatic BRCA-mutations OR ii) both of the following: cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation or genomic instability AND used in combination with bevacizumab (e.g., Avastin, Myasi). Will be used as maintenance therapy. Prostate cancer: 1) Diagnosis of metastatic castration-resistant prostate cancer. 2) One of the following: a) Both of the following: i) Presence of deleterious or suspected deleterious homologous recombination repair (HRR) gene mutations and ii) Disease has progressed following prior treatment with one of the following: a) enzalutamide (Xtandi), or b) abiraterone (e.g., Zytiga, Yonsa) OR b) All of the following: i) Presence of deleterious or suspected deleterious BRCA-mutation, ii) Used in combination with abiraterone (e.g., Zytiga, Yonsa), and iii) Used in combination with Prednisone or Prednisolone. 3) One of the following: a) used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)], or b) Patient has had bilateral orchiectomy. All indications: Approve for continuation of prior therapy if within the past 180 days.

LYTGOBI - UAW TRUST

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of intrahepatic cholangiocarcinoma. Disease is one of the following: a) unresectable locally advanced, or b) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. Patient has been previously treated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

MARGENZA - UAW TRUST

Products Affected

- Margenza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Disease is metastatic. Used in combination with chemotherapy (e.g., capecitabine, eribulin, gemcitabine, vinorelbine). Patient has received two or more prior anti-HER2 regimens (e.g., pertuzumab + trastuzumab + docetaxel, ado-trastuzumab emtansine, etc.), at least one of which was for metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	8 to 16 weeks. Criteria applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

MEKINIST - UAW TRUST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600 mutant type. Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type. Involvement of lymph nodes following complete resection. Used as adjuvant therapy. Medication is used in combination with Tafinlar (dabrafenib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type AND medication is used in combination with Tafinlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of ATC. One of the following: 1) Disease is one of the following: metastatic, locally advanced, or unresectable OR 2) Prescribed as adjuvant therapy following resection. Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib). Solid tumors: Presence of solid tumor. Disease is unresectable or metastatic. Patient has progressed on or following prior systemic treatment (e.g., carboplatin, 5-fluorouracil, paclitaxel). Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

MEKTOVI - UAW TRUST

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Patient is positive for BRAF V600 mutation. Used in combination with Braftovi (encorafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

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	Age 41 or older, or diagnosis of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	No Prior Authorization if patient is age 41 or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MEPSEVII

Products Affected

- Mepsevii

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mucolysacchardidosis VII (MPS ViI, Sly syndrome)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MIFEPRISTONE

Products Affected

- Mifepristone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Termination of intrauterine pregnancy: Prescribed medication will be used for the medical termination of intrauterine pregnancy. Provider attests patient requires treatment for purposes identified in the Hyde Amendment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Idiopathic Hypersomnia (initial): Dx of idiopathic hypersomnia as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA,SWD,MS Fatigue,Hypersomnia,Depression:Initial,Reauth:6 mo.Narcolepsy:Initial,Reauth:Plan Yr

Other Criteria	OSA, Narcolepsy, Idiopathic Hypersomnia (Reauth): Documentation of positive clinical response to therapy. SWD (Reauth): Documentation of positive clinical response to therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with therapy. Depression (reauth): Documentation of positive clinical response to therapy. Used as adjunctive therapy.

MONJUVI - UAW TRUST

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient is not eligible for autologous stem cell transplant (ASCT)
Required Medical Information	Diffuse Large B-cell Lymphoma (DLBCL): Diagnosis of DLBCL, Disease is one of the following: Relapsed or Refractory, Used in combination with lenalidomide
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Baseline platelet count is less than 50,000/mcL. Patient has chronic liver disease and is scheduled to undergo a procedure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency. Reauth: Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by an endocrinologist.
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Initial: One of the following: a) Diabetes mellitus or insulin resistance with persistent hyperglycemia (HgbA1C greater than 7.0%) despite insulin therapy at maximum tolerated doses OR b) Persistent hypertriglyceridemia (TG greater than 250mg/dL) despite therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses.

MYFEMBREE

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Uterine Leiomyomas (Fibroids) (initial): Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (initial): Diagnosis of moderate to severe pain associated with endometriosis. Patient is premenopausal. One of the following: 1) History of inadequate pain control response following a trial of 30 days, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progestin) contraceptive, or progestins or 2) Patient has had surgical ablation to prevent recurrence. Treatment duration of Myfembree has not exceeded a total of 24 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications (initial, reauth): Plan year (up to 24 months per lifetime).
Other Criteria	Uterine Leiomyomas (fibroids) (reauth): Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.). Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (reauth): Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain). Treatment duration of Myfembree has not exceeded a total of 24 months.

MYLOTARG - UAW TRUST

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML) or relapsed/refractory (R/R) AML. Disease is CD33-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

MYTESI

Products Affected

- Mytesi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HIV/AIDS-associated non-infectious diarrhea. Patient is on antiretroviral therapy [e.g., Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide), Dovato (dolutegravir/lamivudine), Triumeq (dolutegravir/abacavir/lamivudine)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypoparathyroidism (initial): Diagnosis of hypoparathyroidism. Used as adjunctive therapy at treatment initiation. Hypoparathyroidism (reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial authorization: Prescribed by an endocrinologist
Coverage Duration	Initial: 6 months Reauthorization: plan year
Other Criteria	N/A

NAYZILAM - UAW TRUST

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epilepsy: Diagnosis of epilepsy. Frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

NERLYNX - UAW TRUST

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Early Stage Breast cancer: Diagnosis (dx) of early stage breast cancer. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Patient has received adjuvant trastuzumab based therapy (e.g., Herceptin, Kanjinti, etc.). Advanced or Metastatic Breast Cancer: 1) All of the following: Dx of advanced or metastatic breast cancer. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Patient has received two or more prior anti-HER2 based regimens (e.g., trastuzumab + pertuzumab + docetaxel, ado-trastuzumab emtansine, etc.). Used in combination with capecitabine OR 2) Both of the following: Diagnosis of Stage IV (M1) breast cancer. Hormone receptor-positive, (HER2)-negative disease in patients who have already received a CDK4/6 inhibitor therapy or triple negative disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

NEUPOGEN - UAW TRUST

Products Affected

- Neupogen
- Nivestym
- Zarxio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), myelodysplastic syndromes (MDS), drug induced agranulocytosis or neutropenia, aplastic anemia (AA), acute lymphocytic leukemia (ALL), radiation syndrome - hematopoietic syndrome of acute radiation syndrome (for Nivestym and Zarxio)
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	AML, HIV/AIDS, MDS (initial) - 18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Auth for chemo - 6 mos. Auth for HS-ARS - 1 mo. Auth for all other indications - 3 mos.
Other Criteria	Cancer patients receiving chemotherapy - patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (e.g., aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver or renal dysfunction, poor performance status, HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (e.g., Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (e.g., sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection). Patients are

	required to try Nivestym or Zarxio prior to approval of Neupogen unless patient has initiated therapy with Neupogen and requires additional medication to complete the current cycle of chemotherapy.

NEXAVAR - UAW TRUST

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	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. One of the following: patient has metastatic disease, or patient has extensive liver tumor burden, or patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or disease is unresectable. Differentiated thyroid carcinoma (DTC): Diagnosis of one of the following: follicular carcinoma, Hurthle cell carcinoma, or papillary carcinoma. One of the following: metastatic disease, unresectable recurrent disease, or persistent locoregional disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment. Medullary thyroid carcinoma (MTC): Diagnosis of MTC and one of the following: a) disease is progressive or disease is symptomatic with distant metastases. Trial and failure, contraindication, or intolerance to one of the following: Caprelsa (vandetanib) or Cometriq (cabozantinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

NINLARO - UAW TRUST

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. One of the following: 1) Both of the following: Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)] AND Used as part of combination regimen including dexamethasone [combination regimen may include additional agents, such as Revlimid (lenalidomide)] OR 2) Both of the following: a) Used as primary therapy and b) Used in combination with dexamethasone and Revlimid (lenalidomide) OR 3) Both of the following: a) Patient is a transplant candidate and b) Patient has symptomatic disease following response to primary myeloma therapy or response or stable disease following autologous stem cell transplant
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

NOURIANZ

Products Affected

- Nourianz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing "off" episodes. Medication will be used in combination with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B inhibitor (e.g., rasagiline, selegiline), Dopamine Agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PD (initial, reauth): Plan year
Other Criteria	PD (reauth): Documentation of positive clinical response to therapy. Used in combination with carbidopa/levodopa.

NPLATE

Products Affected

- Nplate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune thrombocytopenia (ITP): Diagnosis of one of the following: a) ITP or b) relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., dexamethasone, prednisone), immune globulins (e.g., Gammaplex, Gammagard S/D), or splenectomy. Hematopoietic syndrome of acute radiation syndrome: Diagnosis of hematopoietic syndrome of acute radiation syndrome. Patient is acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	N/A
Prescriber Restrictions	ITP, Hematopoietic syndrome of acute radiation syndrome: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP: Plan Year. Hematopoietic syndrome of acute radiation syndrome: 14 days.
Other Criteria	N/A

NUBEQA - UAW TRUST

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-metastatic castration-resistant or castration-recurrent prostate cancer (NM-CRPC): Diagnosis of non-metastatic castration-resistant (chemical or surgical) or castration-recurrent prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin]) OR 2) Patient received bilateral orchiectomy. Metastatic hormone-sensitive prostate cancer (mHSPC): Diagnosis of mHSPC. Used in combination with docetaxel. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin]) OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	NM-CRPC, mHSPC: Plan year
Other Criteria	NM-CRPC, mHSPC: Approve for continuation of prior therapy if within the past 180 days.

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Severe eosinophilic asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by (1) Baseline (pre-treatment) peripheral blood eosinophil level is greater than or equal to 150 cells/microliter or (2) peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months. Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months or Patient has had a prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with both a high dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and additional asthma controller medication [e.g., leukotriene receptor antagonist (e.g., montelukast), long-acting beta-2 agonist (LABA) (e.g., salmeterol), tiotropium], OR one maximally-dosed combination ICS/ LABA product (eg, Advair [fluticasone propionate/ salmeterol], Symbicort [budesonide/ formoterol], Breo Ellipta [fluticasone/vilanterol]), unless there is a contraindication or intolerance to these medications. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy.
Age Restrictions	Severe asthma initial: Age greater than or equal to 6 years
Prescriber Restrictions	Severe asthma (initial): Prescribed by or in consultation with a pulmonologist or allergy/immunology specialist. CRSwNP (init): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist.

Coverage Duration	Asthma (init): 6 mo, Asthma (reauth): plan year. CRSwNP, EGPA, HES (Initial, reauth): plan year
Other Criteria	Hypereosinophilic Syndrome (HES) (init): Diagnosis of HES. Patient has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is FIP1L1-PDGFRA-negative. Patient has uncontrolled HES defined as both of the following: a) History of 2 or more flares within the past 12 months AND b) Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication, or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). Severe asthma (reauth): Documentation of positive clinical response to therapy (eg, reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications). Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium), unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS, 0-8 scale], improvement in nasal obstruction symptoms via visual analog scale [VAS, 0-10 scale]). Used in combination with another agent for CRSwNP. EGPA (reauth): Documentation of positive clinical response to therapy (e.g., increase in remission time). HES (reauth): Documentation of positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose).

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	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA, confirmed by one of the following: 1) Physician attestation that a baseline Center for Neurologic Studies Lability Scale (CNS-LS) score has been assessed OR 2) Patient attestation that patient has experienced involuntary, sudden, or frequent episodes of laughing and/or crying. Patient has a brain injury or neurologic disease from one of the following: amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, stroke, or traumatic brain injury. Patient does not have any of the following contraindications: a) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block.
Age Restrictions	N/A
Prescriber Restrictions	PBA (initial/reauth): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist.
Coverage Duration	PBA (initial/reauth): plan year
Other Criteria	PBA (reauth): One of the following: 1) Physician attestation that the patient’s CNS-LS score has improved since baseline OR 2) Physician attestation that frequency of laughing and/or crying episodes has decreased since baseline. Diagnosis of PBA. Patient has a brain injury or neurologic disease from one of the following: amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, stroke, or traumatic brain injury. Patient does not have any of the following contraindications: a)

	Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block.

NULIBRY

Products Affected

- Nulibry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Both of the following: a) Diagnosis of molybdenum cofactor deficiency (MoCD) Type A AND b) Genetic mutation in the MOCS1 gene. Patient has clinical and/or laboratory signs and symptoms consistent with MOCD Type A (e.g., seizures, limb/axial hypertonia, elevated levels of urinary sulfite/SSC [s-sulfocysteine] or xanthine in blood/urine, low uric acid in blood/urine).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial, Reauth: Plan year
Other Criteria	Reauth: Patient continues to benefit from medication

NUPLAZID - UAW TRUST

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	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Acute Treatment of Migraine (initial): Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor. Preventive Treatment of Episodic Migraine (EM) (initial): Diagnosis of EM with both of the following: 1) Less than or equal to 18 headache days per month and 2) Patient has 4 to 18 migraine days per month. Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) Topiramate (Topamax), e) Venlafaxine (Effexor), f) Candesartan (Atacand). Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications (initial, reauth): Plan year
Other Criteria	Acute Treatment of Migraine (reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Medication will not be used in combination with another oral CGRP inhibitor. Preventive Treatment of EM (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Biliary Cholangitis (PBC) (initial): Diagnosis of PBC (aka primary biliary cirrhosis). One of the following: a) patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND used in combination with UDCA, OR b) history of contraindication or intolerance to UDCA. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).
Age Restrictions	N/A
Prescriber Restrictions	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	PBC (initial): 6 months. (reauth): Plan Year
Other Criteria	PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (ie, prior to obeticholic acid therapy) while receiving therapy. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).

OCREVUS - UAW TRUST

Products Affected

- Ocrevus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing forms of multiple sclerosis (initial): Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Failure after a trial of at least 4 weeks, contraindication, or intolerance to one of the following: A) Aubagio (teriflunomide), B) Kesimpta (ofatumumab), C) Lemtrada (alemtuzumab), D) Mavenclad (cladribine), E) Plegridy (peginterferon beta-1a), F) Tysabri (natalizumab), G) Any one of the interferon beta-1a injections (eg, Avonex), H) Any one of the interferon beta-1b injections (eg, Betaseron, Extavia), I) Any one of the oral fumarates (eg, brand Tecfidera, generic dimethyl fumarate), J) Any one of the glatiramer acetates (eg, Copaxone, Glatopa, generic glatiramer acetate), K) Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (eg, Gilenya [fingolimod], Mayzent [siponimod], Zeposia [ozanimod]), OR 2) For continuation of prior therapy if within the past 180 days. Primary progressive MS (initial): Diagnosis of primary progressive multiple sclerosis (PPMS). All indications (initial, reauth): Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]). Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): Plan Year
Other Criteria	All indications (reauth): Documentation of positive clinical response to therapy.

OCTREOTIDE - UAW TRUST

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	Acromegaly (initial): Diagnosis of acromegaly confirmed by one of the following: serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test at the time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis. One of the following: A) Inadequate response to surgery, radiotherapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy, or B) Not a candidate for any of the following: surgery, radiotherapy, dopamine agonist (e.g., bromocriptine, cabergoline) therapy. HIV/AIDS-Related Diarrhea (initial): Diagnosis of HIV/AIDS-related diarrhea. Carcinoid tumors, symptomatic treatment of diarrhea or flushing (initial): diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive Intestinal Peptide Tumors, symptomatic treatment of diarrhea (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of diarrhea. Cancer Chemotherapy- and/or Radiation- Induced Diarrhea (initial): Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy and/or radiation or uncomplicated diarrhea due to concurrent cancer chemotherapy and/or radiation. Carcinoid tumor: diagnosis of carcinoid tumor. Reauthorization (all except carcinoid tumor): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications (initial, reauth): Plan Year
Other Criteria	Uncomplicated diarrhea due to concurrent cancer chemotherapy and/or radiation (initial): Trial and failure, contraindication, or intolerance (TF/C/I) to standard therapy (e.g., loperamide). HIV/AIDS-related Diarrhea (initial): TF/C/I to standard therapy (e.g., loperamide, diphenoxylate with atropine). Carcinoid tumor: Approve for continuation of prior therapy if within the past 180 days.

ODOMZO - UAW TRUST

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma. One of the following: cancer that has recurred following surgery or radiation therapy, or patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF, defined as exclusion of other known causes of interstitial lung disease and either the presence of usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF in patients not subjected to lung biopsy, or HRCT and surgical lung biopsy pattern revealing IPF or probable IPF in patients subjected to a lung biopsy. Systemic Sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD, defined as exclusion of other known causes of interstitial lung disease (ILD) and either the presence of idiopathic interstitial pneumonia (e.g., fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on HRCT revealing SSc-ILD or probable SSc-ILD in patients not subjected to surgical lung biopsy, or HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD in patients subjected to a lung biopsy. Chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype (initial): Diagnosis of chronic fibrosing ILDs. Patient has a high-resolution computed tomography (HRCT) showing at least 10% of lung volume with fibrotic features. Disease has a progressive phenotype as observed by one of the following: decline of forced vital capacity (FVC), worsening of respiratory symptoms, or increased extent of fibrosis seen on imaging. IPF, SSc-ILD, Chronic Fibrosing ILDs with a progressive phenotype (reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	(initial): Prescribed by or in consultation with a pulmonologist.
Coverage Duration	(initial, reauth): plan year
Other Criteria	N/A

OJJAARA - UAW TRUST

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Patient has anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ONPATTRO

Products Affected

- Onpattro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Patient has a transthyretin (TTR) mutation (e.g., V30M). Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, or a baseline neuropathy impairment score (NIS) between 5 and 130. Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy).
Age Restrictions	N/A
Prescriber Restrictions	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	hATTR amyloidosis (initial, reauth): Plan Year
Other Criteria	Subject to Part B vs D review. hATTR amyloidosis (reauth): Patient has demonstrated a benefit from therapy (e.g., improved neurologic impairment, slowing of disease progression, quality of life assessment). Patient continues to have a PND score less than or equal to IIIb, a FAP stage of 1 or 2, or a NIS between 5 and 130.

ONUREG - UAW TRUST

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML). Patient has received previous treatment with an intensive induction chemotherapy regimen (e.g., cytarabine + daunorubicin, cytarabine + idarubicin). Patient has achieved one of the following: a) first complete remission (CR) or b) complete remission with incomplete blood count recovery (CRi). Patient is not a candidate for intensive curative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

OPDIVO - UAW TRUST

Products Affected

- Opdivo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	All indications: Approve for continuation of prior therapy if within the past 180 days.

OPDUALAG - UAW TRUST

Products Affected

- Opdualag

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: unresectable melanoma or metastatic melanoma. Patient weighs at least 40 kg (88 lbs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

OPHTHALMIC IMMUNOMODULATORS - UAW TRUST

Products Affected

- Cequa
- Xiidra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use of ophthalmic anti-inflammatory drugs
Required Medical Information	Diagnosis of keratoconjunctivitis based on objective test such as Schirmers: test results - 10mm or less of moisture after 5 minutes OR non-invasive tear breakup time, osmolarity or ocular surface staining
Age Restrictions	16 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

ORENCIA IV - UAW TRUST

Products Affected

- Orencia INJ 250MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (i.e., Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. One of the following: TF/C/I to two of the following: Enbrel (etanercept), Formulary adalimumab product (i.e., Humira, Cyltezo, Yuflyma), Xeljanz (tofacitinib) OR for continuation of prior therapy if within the past 180 days. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel (etanercept), Formulary adalimumab product (i.e., Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [Xeljanz/Xeljanz XR (tofacitinib) or Rinvoq (upadacitinib)], PDE4 [Otezla (apremilast)], OR for continuation of prior therapy if within the past 180 days. Acute graft versus host disease (aGVHD): Used for prophylaxis of aGVHD. Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT. Used in combination with both of the following: calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	RA, JIA, PsA (initial): 6 months, (reauth): plan year. aGVHD: 2 months.

Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

ORENCIA SC - UAW TRUST

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	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Two of the following: TF/C/I to Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Xeljanz (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: Trial and failure, contraindication, or intolerance to two agents from the following different mechanisms of action: TNF [Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [Xeljanz/Xeljanz XR (tofacitinib) or Rinvoq (upadacitinib)], OR for continuation of prior therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All indications (Initial): 6 months, (Reauth): plan year
Other Criteria	RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement

	in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

ORGOVYX - UAW TRUST

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ORIAHNN

Products Affected

- Oriahnn

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year (up to 24 months per lifetime)
Other Criteria	Reauth: Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.). Treatment duration of therapy has not exceeded a total of 24 months.

ORKAMBI

Products Affected

- Orkambi TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (initial): Diagnosis of cystic fibrosis (CF). Submission of laboratory records confirming the patient is homozygous for the F508del mutation in the CFTR gene. (Reauthorization): Prescriber attests that the patient has achieved a clinically meaningful response while on Orkambi therapy to one of the following: lung function as demonstrated by percent predicted forced expiratory volume in 1 second (ppFEV1), body mass index (BMI), pulmonary exacerbations, quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score.
Age Restrictions	Patient is greater than or equal to 6 years of age
Prescriber Restrictions	CF (initial, reauthorization): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	N/A

ORKAMBI GRANULES

Products Affected

- Orkambi PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (initial): Diagnosis of cystic fibrosis (CF). Submission of laboratory records confirming the patient is homozygous for the F508del mutation in the CFTR gene. One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.
Age Restrictions	N/A
Prescriber Restrictions	CF (initial, reauthorization): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	CF (Reauthorization): Prescriber attests that the patient has achieved a clinically meaningful response while on Orkambi therapy to one of the following: lung function as demonstrated by percent predicted forced expiratory volume in 1 second (ppFEV1), body mass index (BMI), pulmonary exacerbations, quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score. One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.

ORSERDU - UAW TRUST

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. One of the following: a) Patient is male, or b) Patient is a postmenopausal woman. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor (ESR1) mutation(s). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

OSPHENA

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia: Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness: Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

OTEZLA - UAW TRUST

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA, initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two agents from the following different mechanisms of actions: TNF [Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [Xeljanz/Xeljanz XR (tofacitinib) or Rinvoq (upadacitinib)], OR 2) for continuation of prior therapy if within the past 180 days. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. One of the following: 1) Patient has mild plaque psoriasis, OR 2) Both of the following: a) Patient has moderate to severe plaque psoriasis AND b) Trial and failure, contraindication, or intolerance to two agents from the following different mechanisms of actions: TNF [Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)]. Oral ulcers associated with Behcet's Disease (initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with one of the following specialists: dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): plan year.
Other Criteria	PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.

	Oral ulcers associated with Behcet's Disease (reauth): Documentation of positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).

OXANDROLONE

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bone Pain: Diagnosis of bone pain due to osteoporosis. AIDS Wasting: Diagnosis of AIDS wasting or cachexia associated with AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: plan year
Other Criteria	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurotrophic keratitis (NK): Diagnosis of NK.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	8 weeks.
Other Criteria	N/A

OXLUMO

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Hyperoxaluria Type 1 (PH1) (initial): Diagnosis of PH1. Diagnosis has been confirmed by both of the following: 1) One of the following: a) Elevated urinary oxalate excretion, b) Elevated plasma oxalate concentration, or c) Spot urinary oxalate to creatinine molar ratio greater than normal for age, AND ONE of the following: 1) Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene OR 2) Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity. Patient has not received a liver transplant.
Age Restrictions	N/A
Prescriber Restrictions	PH1 (initial, reauth): Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
Coverage Duration	PH1 (initial, reauth): Plan year.
Other Criteria	PH1 (reauth): Documentation of positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration). Patient has not received a liver transplant.

PADCEV - UAW TRUST

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Cancer: Diagnosis of locally advanced or metastatic urothelial cancer. Both of the following: 1) Patient has received prior treatment with one of the following immune checkpoint inhibitors (CPI): a) Programmed death receptor-1 (PD-1) inhibitor [e.g.,Opdivo (nivolumab), Keytruda (pembrolizumab)] or b) Programmed death-ligand 1 (PD-L1) inhibitor [e.g., Tecentriq (atezolizumab), Imfinzi (durvalumab), Bavencio (avelumab)] and 2) One of the following: a) Patient has received prior treatment with a platinum-based chemotherapy (e.g., carboplatin, cisplatin) or b) Patient is ineligible for cisplatin-containing chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PALYNZIQ

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management (e.g., Kuvan [sapropterin]). One of the following: Patient has had a trial and failure or intolerance to Kuvan (sapropterin) or patient is not a candidate for Kuvan (sapropterin) therapy due to the presence of two null mutations in trans. Patient will have phenylalanine blood levels measured every 4 weeks until a maintenance dose is established and periodically thereafter.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (initial, reauth): Plan year
Other Criteria	PKU (reauth): Documentation of positive clinical response to therapy. Patient will continue to have phenylalanine blood levels measured periodically during therapy.

PANRETIN - UAW TRUST

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Kaposi's sarcoma lesions: Diagnosis of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma (KS). Not used when systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PEGFILGRASTIM PREFERRED

Products Affected

- Fulphila
- Neulasta
- Neulasta Onpro Kit
- Udenyca
- Ziextenzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neutropenia Associated with Dose Dense Chemotherapy (NDDC): Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, or a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia is unknown. Chemotherapy-Induced Febrile Neutropenia (CFN): Patient is receiving a chemotherapy regimen associated with greater than 20% incidence of febrile neutropenia, or patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has 1 or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. Secondary prophylaxis of FN: For patients who are receiving myelosuppressive anticancer drugs associated with neutropenia. Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ARS: 1 mo. CFN, NDDC, FN (prophylaxis): 3 mo or duration of tx.
Other Criteria	N/A

PEMAZYRE - UAW TRUST

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced or metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Patient has been previously treated. Myeloid/Lymphoid neoplasms: Diagnosis of myeloid/lymphoid neoplasm (MLNs). Disease is relapsed or refractory. Disease has presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PEMFEXY - UAW TRUST

Products Affected

- Pemetrexed INJ 100MG, 500MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Malignant Pleural Mesothelioma: Diagnosis of malignant pleural mesothelioma. Used in combination with cisplatin for initial treatment. One of the following: 1) Disease is unresectable, OR 2) Patient is not a candidate for curative surgery. Non-squamous Non-Small Cell Lung Cancer (NSCLC): Diagnosis of non-squamous NSCLC. One of the following: 1) Both of the following: a) Disease is locally advanced or metastatic and b) Used in combination with cisplatin for initial treatment, OR 2) All of the following: a) Disease is locally advanced or metastatic, b) Used as a single agent for maintenance treatment, and c) Disease has not progressed after four cycles of platinum-based first-line chemotherapy (e.g., cisplatin, carboplatin), OR 3) All of the following: a) Disease is recurrent, b) Disease is metastatic, and c) Used as a single agent after prior chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PENICILLAMINE

Products Affected

- Penicillamine CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Both of the following: 1) One of the following: A) Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration), B) diagnosis of cystinuria AND trial and failure, contraindication, or intolerance to Thiola (tiopronin), or C) Diagnosis of severe active rheumatoid arthritis AND patient has been unresponsive to conventional therapy (e.g., traditional DMARDs [e.g., methotrexate, sulfasalazine], TNF inhibitor [e.g., Humira (adalimumab), Enbrel (etanercept)], Non-TNF biologic [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]) AND 2) Trial and failure or intolerance to Depen (penicillamine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PENTOBARBITAL - UAW TRUST

Products Affected

- Pentobarbital Sodium INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Convulsive episodes: Used for the emergency control of acute convulsive episodes (e.g., those associated with status epilepticus, cholera, eclampsia, meningitis, tetanus, and toxic reactions to strychnine or local anesthetics)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Convulsive episodes: Approve for continuation of prior therapy if within the past 180 days. All indications: If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

PHESGO - UAW TRUST

Products Affected

- Phesgo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PIQRAY - UAW TRUST

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	Breast Cancer (BC): Diagnosis of advanced or metastatic BC. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Presence of one or more PIK3CA mutations. Patient is one of the following: a) postmenopausal woman, b) premenopausal woman with ovarian ablation/suppresion, or c) male. Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

POLIVY - UAW TRUST

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	B-cell lymphoma: Diagnosis of large B-cell lymphoma. Disease is relapsed or refractory. Used in combination with bendamustine and a rituximab product. Patient has received at least two prior therapies for DLBCL (e.g., RCHOP [rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone], HSCT [hematopoietic stem cell transplantation], CAR T [chimeric antigen receptor T-cell] therapy, RCEPP [rituximab, cyclophosphamide, etoposide, prednisone, procarbazine], GemOx [gemcitabine, oxaliplatin] with or without rituximab)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

POMALYST - UAW TRUST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with dexamethasone. Trial and failure, contraindication or intolerance to both an immunomodulatory agent [eg, Revlimid (lenalidomide)] and a proteasome inhibitor [eg, Velcade (bortezomib)]. Kaposi sarcoma (KS): One of the following: 1) Both of the following: a) Diagnosis of AIDS-related KS and b) Patient has failed highly active antiretroviral therapy (HAART) [e.g., Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide), Dovato (dolutegravir/lamivudine), Triumeq (dolutegravir/abacavir/lamivudine)], OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

POSACONAZOLE

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	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 [eg, acute myeloid leukemia (AML), myelodysplastic syndrome (MDS)], OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment of IFI: Used as treatment of invasive fungal infections caused by Aspergillus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of IFI: plan year. Treatment of IFI: 3 months.
Other Criteria	N/A

POTELIGEO - UAW TRUST

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mycosis fungoides (MF) or Sezary syndrome (SS). Disease is relapsed or refractory. Patient has received at least one prior systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD(init): One of the following diagnoses: A) HeFH as confirmed by one of the following: (1) Both of the following: a) Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, AND b) One of the following: i) Family history (hx) of tendinous xanthomas and/or arcus cornealis in 1st degree relative, or 2nd degree relative, ii)Hx of myocardial infarction (MI) in 1st-degree relative less than 60 years of age, iii) Family hx of MI in 2nd-degree relative less than 50 years of age, iv) Family hx of LDL-C greater than 190 mg/dL in 1st- or 2nd-degree relative, v) Family hx of FH in 1st- or 2nd-degree relative, or (2) Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult 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. OR B) Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. OR C) Primary Hyperlipidemia (HLD). HoFH (initial): dx of HoFH as confirmed by one of the following: (1) Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or (2) either untreated LDL greater than 500 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	HeFH/ASCVD/Primary HLD (init): One of the following: A) One of the following LDL-C values while on maximally tolerated lipid lowering tx within the last 120 days: (1) LDL-C greater than or equal to 70 mg/dL with ASCVD or (2) LDL-C greater than or equal to 100 mg/dL without ASCVD, OR B) Both of the following: (1) Patient has been receiving

	PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy and (2) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering therapy has shown a reduction from baseline. One of the following: A) Pt has been receiving at least 12 weeks of one maximally-tolerated statin tx and will continue to receive a statin at maximally tolerated dose, B) pt is unable to tolerate statin tx as evidenced by intolerable and persistent (ie, more than 2 wks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times ULN, C) patient has a labeled contraindication to all statins, OR D) Pt has experienced rhabdomyolysis or muscle symptoms with statin tx with CK elevations greater than 10 times ULN on one statin tx. HoFH (init): Pt is receiving other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive statin at the maximally tolerated dose (unless pt has documented inability to take statins). HoFH (reauth): Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient has experienced LDL-C reduction while on Praluent therapy. HeFH/ASCVD/Primary HLD/HoFH (initial/reauth): Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided. HoFH (Init, reauth): Not used in combo w/ Juxtapid.

PREVYMIS INJECTION

Products Affected

- Prevymis INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of Cytomegalovirus (CMV): Used for prophylaxis of CMV infection and disease, patient is a CMV-seropositive recipient [R+] of an allogeneic hematopoietic stem cell transplant (HSCT), and patient is unable to take oral therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, physician experienced in the management of transplant patients, or infectious disease specialist
Coverage Duration	4 months
Other Criteria	N/A

PREVYMIS ORAL

Products Affected

- Prevymis TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cytomegalovirus (CMV) Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT): Used for prophylaxis of CMV infection and disease AND patient is a CMV-seropositive recipient [R+] of an allogeneic HSCT. CMV Prophylaxis in Kidney Transplant: Used for prophylaxis of CMV infection and disease. Patient is a CMV-seronegative recipient [R-]. Patient is receiving a kidney transplant from a CMV-seropositive donor [D+].
Age Restrictions	N/A
Prescriber Restrictions	CMV Prophylaxis in HSCT: Prescribed by or in consultation with an oncologist, hematologist, physician experienced in the management of transplant patients, or infectious disease specialist. CMV Prophylaxis in Kidney Transplant: Prescribed by or in consultation with a nephrologist, physician experienced in the management of transplant patients, or infectious disease specialist.
Coverage Duration	CMV Prophylaxis in HSCT: 4 months. CMV Prophylaxis in Kidney Transplant: 7 months.
Other Criteria	N/A

PROMACTA - UAW TRUST

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thrombocytopenia in myelodysplastic syndrome (MDS)
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of immune thrombocytopenia (ITP) or diagnosis of thrombocytopenia in myelodysplastic syndrome (MDS) or diagnosis of aplastic anemia or diagnosis of thrombocytopenia in hepatitis C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	ITP - patient has tried ONE other therapy or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis- allow for initiation of antiviral therapy if the patient has low platelet counts (e.g., less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy. Aplastic anemia - low platelet counts at baseline/pretreatment (e.g., less than 30,000 mm3) AND previous trial of one immunosuppressant therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus, Atgam) OR patient will be using Promacta in combination with standard immunosuppressive therapy. MDS - low- to intermediate-risk MDS AND according to the prescriber the patient has clinically-significant thrombocytopenia (e.g., low platelet counts [pretreatment], is platelet transfusion-dependent, active bleeding, and/or a history of bleeding at low platelet counts).

PYRUKYND

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count). Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene: a) Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant AND b) Patients is not homozygous for the c.1436G to A (p.R479H) variant AND c) Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene. Hemoglobin is less than or equal to 10g/dL. Patient has symptomatic anemia or is transfusion dependent. Exclusion of other causes of hemolytic anemias (e.g., infections, toxins, drugs).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: Plan Year.
Other Criteria	Reauth: Documentation of positive clinical response to therapy.

QINLOCK - UAW TRUST

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): Diagnosis of gastrointestinal stromal tumor (GIST). Disease is one of the following: a) advanced, b) metastatic, c) unresectable, or d) recurrent. One of the following: a) Trial and failure, contraindication, or intolerance to all of the following: imatinib (Gleevec), sunitinib (Sutent), and regorafenib (Stivarga), b) All of the following: performance status 0-2, history of progression on imatinib (Gleevec), and history of intolerance to sunitinib (Sutent), or c) All of the following: PDGFRA exon 18 mutations that are insensitive to imatinib (Gleevec) (including PDGFRA D842V), history of progression on avapritinib (Ayvakit), and history of progression on dasatinib (Sprycel).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Diagnosis (dx) of uncomplicated malaria and one of the following: treatment in areas of chloroquine-sensitive malaria or treatment in areas of chloroquine-resistant malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Chloroquine-sensitive malaria: Failure, contraindication or intolerance to chloroquine or hydroxychloroquine.

RADICAVA

Products Affected

- Radicava

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic lateral sclerosis (ALS) (initial): Documentation of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment. Documentation confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment. ALS (initial, reauth): Diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) per the revised EL Escorial diagnostic criteria. Radicava dosing for ALS is in accordance with the United States Food and Drug Administration approved labeling.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	6 months (Initial and reauth)
Other Criteria	ALS (reauthorization): Patient is currently receiving Radicava therapy. Patient is NOT dependent on invasive ventilation or tracheostomy.

RADICAVA ORS

Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic lateral sclerosis (ALS) (initial): Documentation of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment. Documentation confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment. ALS (initial, reauth): Diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the revised EL Escorial diagnostic criteria. Radicava dosing for ALS is in accordance with the United States Food and Drug Administration approved labeling.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial, reauth): Prescribed by or in consultation with a neurologist.
Coverage Duration	ALS (initial, reauth): 6 months
Other Criteria	ALS (reauthorization): Patient is currently receiving Radicava therapy. Patient is NOT dependent on invasive ventilation or tracheostomy.

REBLOZYL

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Beta Thalassemia (initial): One of the following: a) Diagnosis of beta thalassemia major AND patient requires regular red blood cell (RBC) transfusions, OR b) Diagnosis of transfusion-dependent beta thalassemia. MDS-RS, MDS/MPN-RS-T (initial): One of the following diagnoses: a) Very low-to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS), OR b) Myelodysplastic or myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T). Patient has failed an erythropoiesis stimulating agent [e.g., Epogen (epoetin alfa), Aranesp (darbepoetin)]. Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	All uses (initial, reauth): Plan Year
Other Criteria	Beta Thalassemia (reauth): Documentation of a positive clinical response to therapy (e.g., reduction in RBC transfusion burden). MDS-RS, MDS/MPN-RS-T (reauth): Documentation of a positive clinical response to therapy (e.g., RBC transfusion independence, improvement in hemoglobin levels).

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetic Neuropathic Ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Diabetic Neuropathic Ulcers: 5 months.
Other Criteria	N/A

RELISTOR - UAW TRUST

Products Affected

- Relistor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction
Required Medical Information	Diagnosis of opioid induced constipation (OIC), previous therapies including trial date
Age Restrictions	initial: 18 years or age and older.
Prescriber Restrictions	N/A
Coverage Duration	Auth will be 3 mos except for advanced illness/palliative care due to cancer auth will be Plan Year.
Other Criteria	OIC - use of opioid medications for a minimum of 4 weeks AND if request is for the Relistor injection the patient requires an injection due to an inability to take oral Relistor medication. Reauthorization - increase in bowel movements with treatment.

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	HeFH/ASCVD/Primary HLD(init): One of the following dx: A) HeFH as confirmed by one of the following: (1) Both of the following: a) Untreated/pre-treatment LDL greater than 190 mg/dL in an adult, AND b) One of the following: i) Family hx of tendinous xanthomas and/or arcus cornealis in 1st degree relative, or 2nd degree relative, ii)Hx of myocardial infarction (MI) in 1st-degree relative less than 60 years of age, iii) Family hx of MI in 2nd-degree relative less than 50 years of age, iv) Family hx of LDL-C greater than 190 mg/dL in 1st- or 2nd-degree relative, v) Family hx of FH in 1st- or 2nd-degree relative, or (2) Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult 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. OR B)ASCVD as confirmed by ACS, hx of MI, stable or unstable angina, coronary or other arterial revascularization, stroke,TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. OR C) Primary hyperlipidemia (HLD). HoFH (initial): dx of HoFH as confirmed by one of the following: (1) Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or (2) either untreated LDL greater than 500 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	HeFH/ASCVD/Primary HLD (init): One of the following: A) One of the following LDL values while on max tolerated lipid lowering tx w/in the last 120 days: (1) LDL greater than or equal to 70 mg/dL w/ ASCVD or (2) LDL greater than or equal to 100 mg/dL w/o ASCVD, OR B) Both of the following: (1) Patient has been receiving PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy and (2) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering

	therapy has shown a reduction from baseline. One of the following: A) Pt has been receiving at least 12 wks of one max-tolerated statin tx and will continue to receive a statin at max tolerated dose, B) pt is unable to tolerate statin tx as evidenced by intolerable and persistent (ie, more than 2 wks) myalgia (muscle symptoms w/o CK elevations) or myositis (muscle symptoms w/ CK elevations less than 10 times ULN, C) patient has a labeled contraindication to all statins, OR D) Pt has experienced rhabdomyolysis or muscle symptoms w/ statin tx w/ CK elevations greater than 10 times ULN on one statin tx. HoFH (init): Pt is receiving other lipid-lowering tx (eg statin, ezetimibe).HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive statin at max tolerated dose (unless pt has documented inability to take statins). HoFH (reauth): Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Pt has experienced LDL reduction while on Repatha tx. HeFH/ASCVD/Primary HLD/HoFH (Init, reauth): Prescriber attests that the info provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical info necessary to verify the accuracy of the info provided. HoFH (Init, reauth): Not used in combo w/ Juxtapid.

RETEVMO - UAW TRUST

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung cancer: Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) recurrent, b) advanced, or c) metastatic. Presence of RET gene fusion-positive or RET rearrangement positive tumor(s). Medullary Thyroid Cancer (MTC): Diagnosis of medullary thyroid cancer (MTC). Disease is advanced or metastatic. Disease has presence of RET gene mutation. Disease requires treatment with systemic therapy. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is advanced or metastatic. Disease is RET gene fusion-positive. Disease requires treatment with systemic therapy. Patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate. Solid Tumors: Presence of RET gene fusion-positive solid tumor. Disease is recurrent, advanced, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Non-Small Cell Lung Cancer, MTC, Thyroid Cancer, Solid Tumors: Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

REVLIMID - UAW TRUST

Products Affected

- Lenalidomide
- Revlimid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma: Diagnosis of multiple myeloma. Myelodysplastic syndrome (MDS) with a deletion 5q: Diagnosis of symptomatic anemia due to MDS associated with a deletion 5q. Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Follicular Lymphoma (FL): Diagnosis of FL that has been previously treated. Used in combination with a rituximab product. Marginal Zone Lymphoma (MZL): Diagnosis of MZL that has been previously treated. Used in combination with a rituximab product.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

REZLIDHIA - UAW TRUST

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of at least two prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	cGVHD (initial, reauth): Plan year
Other Criteria	cGVHD (reauth): Documentation of positive clinical response to therapy.

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA) (init): Diagnosis (Dx) of moderately to severely active RA. Minimum (min) duration of a 3-mo trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (init): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (init): Dx of active AS. Non-radiographic axial spondyloarthritis (NRAS) (init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, certolizumab pegol). AS, NRAS (init): Min duration of a one-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, NRAS (init, reauth): Not used in combination with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). Atopic dermatitis (AD) (init): Dx of moderate to severe AD. One of the following: Involvement of at least 10% body surface area (BSA), or SCORing Atopic Dermatitis (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for topical corticosteroids), C/I to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus oint, or Eucrisa oint. One of the following: 1) TF of a min 12-wk supply of at least one systemic drug product for the treatment of AD (ex include, but are not limited to, Adbry, Dupixent, etc.), OR 2) Pt has a C/I, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	AD (initial): Patient is 12 years of age or older.
Prescriber Restrictions	RA, AS, NRAS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (initial): Prescribed by or in

	consultation with a dermatologist or allergist/immunologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA, PsA, AS, NRAS, AD, CD, UC (initial): 6 months, (reauth): Plan year.
Other Criteria	Crohn's disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools/day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine). RA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (ESR, CRP level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Documentation of a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine). CD, UC (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, ESR, CRP

	level]) from baseline, OR reversal of high fecal output state. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).

RITUXAN - UAW TRUST

Products Affected

- Rituxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma: As first-line treatment of diffuse large B-cell, CD20-positive, NHL in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, or as first-line treatment of follicular, CD20-positive, B-cell NHL in combination with chemotherapy, or as a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell NHL in patients achieving a complete or partial response to a rituximab product in combination with chemotherapy, or for the treatment of low-grade, CD20-positive, B-cell NHL in patients with stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy or who achieve a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy, or diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell NHL, or diagnosis of previously untreated, advanced stage CD-20-positive diffuse large B-cell lymphoma, Burkitt lymphoma, Burkitt-like lymphoma, or mature B-cell acute leukemia and used in combination with chemotherapy. Rheumatoid arthritis (RA): Diagnosis of moderately to severely active RA. Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Patient is concurrently on glucocorticoids (eg, prednisone) OR history of contraindication or intolerance to glucocorticoids (eg, prednisone). Immune or idiopathic thrombocytopenic purpura (ITP): Diagnosis of immune or idiopathic thrombocytopenic purpura. Chronic Lymphocytic Leukemia (CLL): Diagnosis of CLL. Used in combination with fludarabine and cyclophosphamide. Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses except RA, WG, MPA: plan yr. WG, MPA: 3 months. RA: 1 month.

Other Criteria	Approve for continuation of prior therapy if within the past 180 days. ITP: Trial and failure, contraindication, or intolerance to one of the following: glucocorticoids (e.g., prednisone, methylprednisolone), immune globulins (e.g., IVIG), or splenectomy. Documented platelet count of less than 50x10^9 /L. RA: Used in combination with methotrexate. Trial and failure, contraindication, or intolerance to one TNF antagonist (eg, adalimumab, etanercept, infliximab).

ROFLUMILAST

Products Affected

- Daliresp
- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD) (initial): Diagnosis of COPD. History of COPD exacerbations which required the use of systemic corticosteroids, antibiotics, or hospital admission. Trial and failure, intolerance, or contraindication to two prior therapies for COPD (e.g., Combivent, Spiriva).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: plan year
Other Criteria	COPD (reauth): Documentation of positive clinical response to therapy.

ROZLYTREK - UAW TRUST

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer (NSCLC). Patient has ROS1 rearrangement positive tumor(s). Solid Tumors: Patient has solid tumors with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.). Disease is without a known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

RUBRACA - UAW TRUST

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Both of the following: 1) Disease is recurrent, and 2) Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin). Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer. Presence of deleterious BRCA mutation. Patient has received previous treatment with both of the following: 1) Androgen receptor-directed therapy [e.g., Erleada (apalutamide), Xtandi (enzalutamide), Zytiga (abiraterone)], AND 2) A taxane-based chemotherapy [e.g., docetaxel, Jevtana (cabazitaxel)]. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin)], OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

RYBREVANT - UAW TRUST

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) locally advanced or b) metastatic. Patient's disease has epidermal growth factor receptor (EGFR) exon 20 insertion mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test. Disease has progressed on or after platinum-based chemotherapy (e.g., carboplatin, cisplatin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

RYDAPT - UAW TRUST

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML), AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive, Rydapt will be used in combination with standard induction and consolidation therapy. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

SAFE DISPENSING - UAW TRUST

Products Affected

- Valrubicin
- Vantas
- Zevalin Y-90

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Physician acknowledges that the product is a dangerous product and requires proper dispensing, storage, and handling
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SAMSCA

Products Affected

- Tolvaptan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of significant hyponatremia (euvolemic or hypervolemic). Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Length of authorization: 30 days
Other Criteria	N/A

SANDOSTATIN LAR - UAW TRUST

Products Affected

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly confirmed by one of the following: serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test at the time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis. One of the following: A) Inadequate response to surgery, radiotherapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy, or B) Not a candidate for any of the following: surgery, radiotherapy, dopamine agonist (e.g., bromocriptine, cabergoline) therapy. Carcinoid tumors, symptomatic treatment of diarrhea or flushing (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive Intestinal Peptide Tumors, symptomatic treatment of diarrhea (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of diarrhea. Carcinoid tumor: Diagnosis of carcinoid tumor. Reauthorization (all except carcinoid tumor): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications: Plan Year
Other Criteria	Carcinoid tumor: Approve for continuation of prior therapy if within the past 180 days.

SARCLISA - UAW TRUST

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma. One of the following: 1) Both of the following: a) Patient has received at least two prior treatment regimens which included lenalidomide and a proteasome inhibitor (e.g., bortezomib, carfilzomib), and b) Used in combination with pomalidomide and dexamethasone, OR 2) All of the following: a) Disease is relapsed or refractory, b) Patient has received one to three prior lines of therapy, and c) Used in combination with carfilzomib and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SCEMBLIX - UAW TRUST

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Disease is Philadelphia chromosome-positive (Ph+). Disease is in chronic phase. One of the following: 1) Patient has been previously treated with two or more alternative tyrosine kinase inhibitors (TKI) [e.g., Bosulif (bosutinib), imatinib, Sprycel (dasatinib), Tasigna (nilotinib), Iclusig (ponatinib)], OR 2) Disease is T315I mutation positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SEROSTIM

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m2, or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m2, or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m2. Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). HIV wasting (reauthorization): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Reauth: 6 months
Other Criteria	N/A

SHINGRIX - UAW TRUST

Products Affected

- Shingrix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vaccine is being used for prevention of herpes zoster (shingles). One of the following: A) Age greater than or equal to 50 years OR B) Both of the following: 1) Age 18 to 49 years and 2) Patient is or will be at increased risk of herpes zoster due to immunodeficiency or immunosuppression caused by known disease or therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months (4 injections per lifetime)
Other Criteria	N/A

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	Cushing's disease: Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SILDENAFIL

Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

SILDENAFIL SUSPENSION

Products Affected

- Sildenafil Citrate SUSR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) History of intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

SIMPONI - UAW TRUST

Products Affected

- Simponi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active rheumatoid arthritis. Used in combination with methotrexate. One of the following: Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 180 days. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx (secukinumab)], IL-23 [Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [Xeljanz/Xeljanz XR or Rinvoq], OR for continuation of prior therapy if within the past 180 days. Ankylosing Spondylitis (AS) (initial): Diagnosis of active AS. One of the following: TF/C/I to two agents from the following different mechanisms of action: TNF [Enbrel, Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma)], IL-17 [Cosentyx], JAK [Rinvoq, Xeljanz/Xeljanz XR], OR for continuation of prior therapy if within the past 180 days. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: TF/C/I to two of the following: Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Stelara, Rinvoq, or Xeljanz/Xeljanz XR, OR for continuation of prior therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration	UC (Initial): 12 weeks. UC (Reauth): plan year. RA, AS, PsA (initial): 6 months, (reauth): plan year
Other Criteria	RA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

SKYCLARYS

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Friedreich's ataxia confirmed via genetic testing demonstrating mutation in the FXN gene. Patient has a Modified Friedreich's Ataxia Rating Scale (mFARS) score of greater than or equal to 20 and less than or equal to 80. Patient has a B-type natriuretic peptide value less than or equal to 200 pg/mL.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Physiatrist (Physical Medicine and Rehabilitation Specialist).
Coverage Duration	Initial, Reauth: Plan Year.
Other Criteria	Reauth: Documentation of positive clinical response to therapy.

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 75MG/0.83ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque Psoriasis (initial): Diagnosis of chronic moderate to severe plaque psoriasis. One of the following: at least 3% body surface area involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): plan year.
Other Criteria	Plaque Psoriasis (reauthorization): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation

	rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

SKYRIZI IV

Products Affected

- Skyrizi INJ 600MG/10ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's disease (CD): Diagnosis of moderately to severely active CD. One of the following: a) frequent diarrhea and abdominal pain, b) at least 10% weight loss, c) complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR d) CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Will be administered as an intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	3 months
Other Criteria	N/A

SOLIRIS - UAW TRUST

Products Affected

- Soliris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH. Prescribed medication is used for induction therapy and will not exceed 600 mg weekly for the first 4 weeks OR Prescribed medication is used for maintenance therapy and will not exceed 900 mg weekly at week 5, then 900 mg every 2 weeks thereafter. Atypical Hemolytic Uremic Syndrome (aHUS) (initial): Diagnosis of aHUS. One of the following: A) For patients 18 years of age and older, prescribed medication is used for induction therapy and will not exceed 900 mg weekly for the first 4 weeks OR Prescribed medication is used for maintenance therapy and will not exceed 1200 mg weekly at week 5, then 1200 mg every 2 weeks thereafter or B) For patients less than 18 years of age, dosing is in accordance with the United States (US) Food and Drug Administration (FDA) approved labeled dosing for aHUS. Generalized Myasthenia Gravis (gMG) (initial): Diagnosis of gMG. Patient is anti-acetylcholine receptor (AChR) antibody positive. One of the following: 1) TF/C/I to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and TF/C/I to chronic plasmapheresis/plasma exchange (PE) or intravenous immunoglobulin (IVIG). Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive. gMG, NMOSD (initial): Prescribed medication is used for induction therapy and will not exceed 900 mg weekly for the first 4 weeks OR Prescribed medication is used for maintenance therapy and will not exceed 1200 mg weekly at week 5, then 1200 mg every 2 weeks thereafter.
Age Restrictions	N/A
Prescriber Restrictions	gMG (initial): Prescribed by or in consultation with a neurologist. NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist.
Coverage Duration	All uses (initial, reauth): plan year

Other Criteria	PNH (reauth): Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy. Prescribed medication is used for maintenance therapy and will not exceed 900 mg every 2 weeks. aHUS (reauth): Documentation of positive clinical response (e.g., increase in mean platelet counts, hematologic normalization) to therapy. One of the following: A) For patients 18 years of age and older, prescribed medication is used for maintenance therapy and will not exceed 1200 mg every 2 weeks or B) For patients less than 18 years of age, dosing is in accordance with the United States (US) Food and Drug Administration (FDA) approved labeled dosing for aHUS. gMG, NMOSD (reauth): Documentation of positive clinical response to therapy. Prescribed medication is used for maintenance therapy and will not exceed 1200 mg every 2 weeks.

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	Acromegaly (Initial): Diagnosis of acromegaly by one of the following: serum growth hormone (GH) level greater than 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis. Inadequate response to one of the following: surgery, radiotherapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy or not a candidate for surgery, radiotherapy or dopamine agonist (eg, bromocriptine, cabergoline) therapy. Trial and failure, contraindication, or intolerance to one of the following somatostatin analogs: Sandostatin (octreotide) or Sandostatin LAR (octreotide) or Somatuline Depot (lanreotide) , or Patient has extremely high IGF-1 values defined as greater than 900 ng/mL. Acromegaly (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acromegaly (Initial, Reauth): plan year
Other Criteria	N/A

SPRAVATO - UAW TRUST

Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Both of the following: 1) Diagnosis of major depressive disorder and 2) Patient has not experienced a clinical meaningful improvement after treatment with at least two antidepressants from different classes for an adequate duration (at least 4 weeks each) in the current depressive episode OR B) Both of the following: 1) Diagnosis of major depressive disorder and 2) Patient has both of the following: a) depressive symptoms and b) acute suicidal ideation or behavior. Used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SPRYCEL - UAW TRUST

Products Affected

- Sprycel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myeloid Leukemia (CML): Diagnosis (dx) of Philadelphia chromosome-positive/BCR ABL-positive chronic myeloid leukemia (Ph+/BCR ABL+ CML). Acute Lymphoblastic Leukemia (ALL): Diagnosis of Philadelphia chromosome-positive/BCR ABL-positive acute lymphoblastic leukemia (Ph+/BCR ABL+ ALL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

STELARA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial regardless of dose): One of the following: at least 3% body surface area involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial regardless of dose): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (initial): Diagnosis of moderately to severely active Crohn's disease. Will be used as a maintenance dose following the intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All indications (initial): 6 months. All indications (reauth): plan year.
Other Criteria	Ulcerative colitis (UC) (initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. Plaque psoriasis (reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.

	PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

STELARA (IV)

Products Affected

- Stelara INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, Azathioprine, Corticosteroid (eg, prednisone), Methotrexate. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	14 days
Other Criteria	Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.

STIVARGA - UAW TRUST

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer (CRC): Diagnosis of advanced or metastatic colorectal cancer. Trial and failure, contraindication, or intolerance to treatment with all the following: oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, fluoropyrimidine-based chemotherapy, and anti-VEGF therapy-based chemotherapy. One of the following: 1) Tumor is RAS mutant-type OR 2) Tumor is RAS wild-type and trial and failure, contraindication, or intolerance to anti-EGFR therapy. Gastrointestinal stromal tumor (GIST): Diagnosis of progressive, locally advanced, unresectable or metastatic GIST. One of the following: 1) First-line therapy as a single agent for succinate dehydrogenase (SDH) deficient GIST with gross residual disease (R2 resection) or 2) Trial and failure, contraindication, or intolerance to imatinib mesylate or sunitinib malate. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. One of the following: 1) Trial and failure or intolerance to Nexavar (sorafenib tosylate) or 2) Used as subsequent-line therapy for disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SULFACETAMIDE LOTION

Products Affected

- Sulfacetamide Sodium LOTN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acne vulgaris.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SUNITINIB - UAW TRUST

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	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. Trial and failure, contraindication, or intolerance to imatinib. Renal Cell Carcinoma (RCC): Diagnosis of RCC and one of the following: (1) Disease has relapsed, or (2) both of the following: medically or surgically unresectable tumor and diagnosis of Stage IV disease, or (3) both of the following: used in adjuvant setting and patient has a high risk of recurrence following nephrectomy, or (4) Disease is advanced. Islet Cell Tumors/Pancreatic Neuroendocrine Tumors (pNET): Both of the following: (1) Diagnosis of islet cell tumors/progressive pNET (2) Disease is one of the following: unresectable, locally advanced or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cystic fibrosis. Submission of laboratory records confirming one of the following: 1) Patient is homozygous for the F508del mutation in the CF transmembrane conductance receptor (CFTR) gene OR 2) Patient has at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence.
Age Restrictions	Initial: Patient is 6 years of age or older
Prescriber Restrictions	Initial/Reauth: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
Coverage Duration	Initial: 6 months, Reauth: Plan year.
Other Criteria	Reauthorization: Documentation of positive clinical response to therapy (i.e., improvement in lung function or decreased number of pulmonary exacerbations).

SYMPAZAN - UAW TRUST

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome: Diagnosis of Lennox-Gastaut syndrome. Used for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome. Dravet syndrome: Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with Diacomit.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

SYNRIBO - UAW TRUST

Products Affected

- Synribo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myeloid leukemia (CML): Diagnosis of chronic phase CML or accelerated phase CML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TABRECTA - UAW TRUST

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). One of the following: a) Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors or b) High level MET amplification in lung cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TADALAFIL (BPH)

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for the treatment of erectile dysfunction only.
Required Medical Information	Benign prostatic hyperplasia (BPH): Diagnosis of BPH. Male Gender.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	BPH: plan year
Other Criteria	BPH: Trial and failure, contraindication, or intolerance to two formulary alpha blockers (e.g., tamsulosin, alfuzosin). 2.5mg strength: Patient has renal insufficiency.

TADALAFIL (PAH)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

TAFAMIDIS

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Patient has a transthyretin (TTR) mutation (e.g., V122I), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) All of the following: i) echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis, ii) scintigraphy scan suggestive of cardiac TTR amyloidosis, and iii) absence of light-chain amyloidosis. One of the following: 1) History of heart failure (HF), with at least one prior hospitalization for HF, OR 2) Presence of clinical signs and symptoms of HF (e.g., dyspnea, edema). Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure.
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): Plan year
Other Criteria	ATTR-CM (reauth): Documentation of positive clinical response to therapy. Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure.

TAFINLAR - UAW TRUST

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma AND cancer is BRAFV600 mutant type. Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type. Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of anaplastic thyroid cancer. One of the following: 1) Disease is one of the following: metastatic, locally advanced, or unresectable OR 2) Prescribed as adjuvant therapy following resection. Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib). Solid tumors: Presence of solid tumor. Disease is unresectable or metastatic. Patient has progressed on or following prior systemic treatment (e.g., carboplatin, 5-fluorouracil, paclitaxel). Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib). Low-grade glioma: Diagnosis of low-grade glioma. Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TAGRISSO - UAW TRUST

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): One of the following: A) All of the following: Diagnosis of NSCLC. Disease is one of the following: 1) advanced, 2) recurrent, or 3)metastatic. One of the following: 1) Used as first-line therapy AND One of the following: a) Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions, or b) Tumors are positive for EGFR exon 21 L858R mutations, or c) Disease is sensitizing EGFR mutation positive, OR 2) Tumors are positive for EGFR T790M mutation AND Trial and failure, contraindication, or intolerance to at least one prior EGFR tyrosine kinase inhibitor (TKI) therapy [e.g., Iressa (gefitinib), Tarceva (erlotinib), Gilotrif (afatinib)]. OR B) All of the following: Diagnosis of NSCLC. One of the following: 1) Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions, OR 2) Tumors are positive for EGFR exon 21 L858R mutations. Both of the following: 1) Patient is receiving as adjuvant therapy, AND 2) Patient has had a complete surgical resection of the primary NSCLC tumor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TALZENNA - UAW TRUST

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) locally advanced or b) metastatic. Presence of deleterious or suspected deleterious germline BRCA-mutations as detected by the FDA-approved companion diagnostic for Talzenna. Prostate cancer: Diagnosis of prostate cancer. Disease is HRR gene-mutated. Disease is metastatic castration-resistant. Taken in combination with Xtandi (enzalutamide). One of the following: a) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR b) Patient has had bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TASIGNA - UAW TRUST

Products Affected

- Tasigna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome-positive/BCR ABL-positive chronic myeloid leukemia (Ph+/BCR ABL+ CML).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazarotene GEL
- Tazorac CREA 0.05%
- Tazorac GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if treatment for cosmetic purposes.
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne). Psoriasis: Diagnosis of psoriasis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TAZVERIK - UAW TRUST

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelioid sarcoma: Diagnosis of epithelioid sarcoma. Disease is one of the following: metastatic or locally advanced. Patient is not eligible for complete resection. Follicular lymphoma: Diagnosis of follicular lymphoma. Disease is one of the following: relapsed or refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TECENTRIQ - UAW TRUST

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TECVAYLI - UAW TRUST

Products Affected

- Tecvayli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma. Disease is relapsed or refractory. Patient has received at least four prior lines of therapy which include all of the following: 1) An immunomodulatory agent (e.g., lenalidomide, thalidomide), 2) A proteasome inhibitor (e.g., bortezomib, carfilzomib), and 3) A CD38-directed monoclonal antibody (e.g., daratumumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TEPEZZA

Products Affected

- Tepezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid eye disease (TED): Diagnosis of TED. Treatment with Tepezza has not exceeded a total of 8 infusions.
Age Restrictions	N/A
Prescriber Restrictions	TED: Prescribed by or in consultation with an endocrinologist, specialist with expertise in the treatment of TED, or ophthalmologist.
Coverage Duration	6 months
Other Criteria	N/A

TEPMETKO - UAW TRUST

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: recurrent, advanced, or metastatic. Tumor is MET exon 14 skipping mutation positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TERIPARATIDE

Products Affected

- Forteo INJ 600MCG/2.4ML
- Teriparatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis or osteopenia or men with primary or hypogonadal osteoporosis or osteopenia (initial): Diagnosis of one of the following: a) postmenopausal osteoporosis or osteopenia or b) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Glucocorticoid-Induced Osteoporosis: See Other Criteria section.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications (initial, reauth): plan year.
Other Criteria	Glucocorticoid-Induced Osteoporosis (initial): Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months. One of the following: 1) BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site), or 2) One of the following

	FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, 3) History of one of the following fractures resulting from minimal trauma: vertebral compression fx, fx of the hip, fx of the distal radius, fx of the pelvis, or fx of the proximal humerus, 4) either glucocorticoid dosing of at least 30 mg per day or cumulative glucocorticoid dosing of at least 5 grams per year. TF/C/I to one bisphosphonate (e.g., alendronate). All uses (initial, reauth): One of the following: 1) Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime, or 2) Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]).

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Huntington's Disease: Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia: Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome: Patient has tics associated with Tourette's syndrome. Trial and failure, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	Tardive dyskinesia: Age greater than or equal to 18 years.
Prescriber Restrictions	Huntington's: Prescribed by a neurologist. Tardive dyskinesia, Tourette's: Prescribed by a neurologist or psychiatrist.
Coverage Duration	Plan year.
Other Criteria	N/A

THALOMID - UAW TRUST

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Erythema Nodosum Leprosum (ENL): Diagnosis (Dx) of moderate to severe ENL. One of the following: used for acute treatment OR used as maintenance therapy for prevention & suppression of cutaneous manifestations of ENL recurrence. Multiple Myeloma (MM): Dx of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TIBSOVO - UAW TRUST

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. AML is isocitrate dehydrogenase-1 (IDH1) mutation-positive. Newly-Diagnosed AML: Diagnosis of newly-diagnosed AML. AML is isocitrate dehydrogenase-1 (IDH1) mutation-positive. One of the following: 1) Patient is greater than or equal to 60 years old OR 2) Patient has comorbidities that preclude the use of intensive induction chemotherapy. Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is locally advanced, unresectable, or metastatic. Cholangiocarcinoma is IDH1 mutation-positive. Disease has progressed on or after systemic treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TIVDAK - UAW TRUST

Products Affected

- Tivdak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cervical cancer. Disease is one of the following: a) recurrent or b) metastatic. Disease has progressed on or after chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TOPICAL RETINOIDS

Products Affected

- Adapalene CREA
- Adapalene GEL
- Adapalene Pump
- Tretinoin CREA
- Tretinoin GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if treatment for cosmetic purposes.
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TOPICAL TESTOSTERONE PRODUCTS - UAW TRUST

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone GEL 10MG/ACT, 20.25MG/1.25GM, 25MG/2.5GM, 40.5MG/2.5GM, 50MG/5GM
- Testosterone SOLN
- Testosterone Pump

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males or diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males or hypogonadism (primary or secondary) in males, serum testosterone level
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [e.g., depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency AND 2) patient had at least one pre-treatment serum testosterone level that was low.

TRANSDERMAL FENTANYL - UAW TRUST

Products Affected

- Fentanyl PT72

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Information	Chronic pain: Diagnosis of chronic pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For pain severe enough to require daily, around the clock, long term opioid treatment (patients with cancer diagnosis, sickle cell disease, in long term care facility, and or in hospice are exempt from PA requirements) - all of the following criteria are met: 1) patient is not opioid naive, AND 2) non opioid therapies are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patients history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (i.e., FDA labeled use) prior to reviewing for quantity exception.

TRASTUZUMAB PREFERRED - UAW TRUST

Products Affected

- Herceptin INJ 150MG
- Kanjinti
- Ogivri INJ 1.1%; 420MG, 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: One of the following: A) diagnosis of HER2-overexpressing breast cancer. One of the following treatment regimens: a) As part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel, b) in combination with docetaxel and carboplatin, c) as monotherapy for the adjuvant treatment of breast cancer following multi-modality anthracycline based therapy (eg, doxorubicin), d) in combination with a taxane (pacitaxel, docetaxel) for the initial treatment of breast cancer, e) as monotherapy for the treatment of metastatic breast cancer that has relapsed following prior chemotherapy, f) in combination with Perjeta (pertuzumab). OR B) Diagnosis of recurrent or stage IV estrogen receptor positive (ER+), human epidermal growth factor receptor 2-positive (HER2+) breast cancer. Patient is a postmenopausal female or patient is a premenopausal female treated with ovarian ablation or suppression or patient is a male receiving testicular steroidogenesis suppression. Used in combination with an aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimedex (anastrozole)]. Metastatic Gastric Cancer: Diagnosis of HER2-overexpressing gastric, esophageal, or gastroesophageal junction advanced or metastatic adenocarcinoma. In combination with systemic chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TREANDA - UAW TRUST

Products Affected

- Bendamustine Hydrochloride INJ 100MG, 25MG
- Treanda INJ 100MG, 25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of indolent B-cell non-Hodgkin's lymphoma, chronic lymphocytic leukemia, or small lymphocytic lymphoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TREPROSTINIL INJ

Products Affected

- Treprostinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	Subject to Part B vs. Part D review.

TRIENTINE

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	Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

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	Initial: Diagnosis of cystic fibrosis. Submission of laboratory results documenting that the patient has at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: F508del mutation OR A mutation in the CFTR gene that is responsive based on in vitro data.
Age Restrictions	Initial: For granule packets: patient is at least 2 to less than 6 years of age. For tablets: patient is 6 years of age or older
Prescriber Restrictions	Initial/Reauth: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
Coverage Duration	Initial: 6 months, Reauth: Plan year.
Other Criteria	Reauthorization: Provider attests that the patient has achieved a clinically meaningful response while on therapy to one of the following: lung function as demonstrated by percent predicted forced expiratory volume in 1 second (ppFEV1), body mass index (BMI), pulmonary exacerbations, quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score.

TRODELVY - UAW TRUST

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Triple Negative Breast Cancer (TNBC): Diagnosis of TNBC. Disease is one of the following: a) unresectable locally advanced or b) metastatic. Patient has received at least two prior therapies for at least one of which is for metastatic disease (e.g., carboplatin, cisplatin, gemcitabine, paclitaxel, docetaxel, capecitabine, etc.). Breast Cancer (BC): Diagnosis of BC. Disease is one of the following: a) unresectable locally advanced, or b) metastatic. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Both of the following: a) patient has received endocrine-based therapy (e.g., tamoxifen, aromatase inhibitors, fulvestrant), and b) patient has received at least two additional systemic therapies in the metastatic setting (e.g., chemotherapy, poly-ADP ribose polymerase (PARP) inhibitor, fam-trastuzumab deruxtecan-nxki). Urothelial Cancer: Diagnosis of urothelial cancer. Disease is one of the following: a) locally advanced or b) metastatic. Patient has previously received both of the following: 1) Platinum-containing chemotherapy (e.g., cisplatin, carboplatin) AND 2) One of the following: a) programmed death receptor-1 (PD-1) inhibitor [e.g., Keytruda (pembrolizumab)], or b) programmed death-ligand 1 (PD-L1) inhibitor [e.g., Bavencio (avelumab)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TRUSELTIQ - UAW TRUST

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cholangiocarcinoma. Disease is one of the following: a) unresectable locally advanced or b) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Patient has been previously treated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TUKYSA - UAW TRUST

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) advanced unresectable or b) metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Used in combination with trastuzumab and capecitabine. Patient has been previously treated with an anti-HER2-based regimen (e.g., trastuzumab, pertuzumab, ado-trastuzumab emtansine) in the metastatic setting. Colorectal cancer: Diagnosis of colorectal cancer (HER2-amplified and RAS and BRAF wild-type). Disease is HER2-positive. Disease is one of the following: a) advanced, b) unresectable, c) metastatic. One of the following: a) patient has previously been treated with one of the following regimens: i) fluoropyrimidine-based chemotherapy, ii) oxaliplatin-based chemotherapy, iii) irinotecan-based chemotherapy or b) patient is not appropriate for intensive therapy. Used in combination with trastuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

TURALIO - UAW TRUST

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tenosynovial Giant Cell Tumor (TGCT): Diagnosis of TGCT. Patient is symptomatic. Patient is not a candidate for surgery due to worsening functional limitation or severe morbidity with surgical removal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	One of the following diagnoses: 1) Postmenopausal osteoporosis or osteopenia, OR 2) Primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year (up to 24 months per lifetime)
Other Criteria	N/A

TYSABRI - UAW TRUST

Products Affected

- Tysabri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). CD (Reauthorization): Documentation of positive clinical response (eg, improved disease activity index) to therapy.
Age Restrictions	N/A
Prescriber Restrictions	CD (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (initial, reauth): plan year. CD (initial): 3 months. CD (Reauth): plan year.
Other Criteria	MS (initial): One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following disease-modifying therapies for MS: A) Aubagio (teriflunomide), B) Lemtrada (alemtuzumab), C) Mavenclad (cladribine), D) Plegridy (peginterferon beta-1a), E) Any one of the interferon beta-1a injections (eg, Avonex), F) Any one of the interferon beta-1b injections (eg, Betaseron, Extavia), G) Any one of the glatiramer acetate injections (eg, Copaxone, Glatopa, generic glatiramer acetate), H) Any one of the oral fumarates (eg, brand Tecfidera, generic dimethyl fumarate), I) Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (eg, Gilenya [fingolimod], Mayzent [siponimod], Zeposia [ozanimod]), J) Any one of the B-cell targeted therapies (eg, Ocrevus [ocrelizumab], Kesimpta [ofatumumab]), 2) Patient is not a candidate for any of the drugs listed as prerequisites due to the severity of their MS, or 3) For continuation of prior therapy if within the last 180 days. MS (initial, reauth): Not used in combination with another disease-modifying therapy for MS. MS (reauth): Documentation of positive clinical response to therapy. CD (Initial): TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone, methylprednisolone), 6-mercaptopurine (6MP [Purinethol], azathioprine

	(Imuran), methotrexate (Rheumatrex, Trexall), aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine). TF/C/I to a TNF-inhibitor (eg, Humira [adalimumab], infliximab). CD (initial and reauth): Not used in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate). Not used in combination with a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or infliximab).

UKONIQ - UAW TRUST

Products Affected

- Ukoniq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Marginal zone lymphoma (MZL): Diagnosis of MZL. Disease is one of the following: relapsed or refractory. Patent has received at least one prior anti-CD20-based regimen (e.g., bendamustine + rituximab, bendamustine + obinutuzumab, etc.). Follicular lymphoma (FL): Diagnosis of FL. Disease is one of the following: relapsed or refractory. Patient has received at least three prior lines of systemic therapy (e.g., bendamustine + rituximab, bendamustine + obinutuzumab, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

UPTRAVI - UAW TRUST

Products Affected

- Uptravi TABS
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy if within the past 180 days. Not taken in combination with a prostanoid/prostacyclin analogue ([e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)].
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

UPTRAVI INJECTION - UAW TRUST

Products Affected

- Uptravi INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [ie, Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [eg, Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy if within the past 180 days. Not taken in combination with a prostanoid/prostacyclin analogue [eg, Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)]. Patient is unable to take oral medications.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A

VALCHLOR - UAW TRUST

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL): Both of the following: 1) diagnosis of Stage IA MF-CTCL OR diagnosis of Stage IB MF-CTCL AND 2) patient has received at least one prior skin-directed therapy (e.g., topical corticosteroids, bexarotene topical gel [Targretin topical gel], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VALTOCO - UAW TRUST

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	Epilepsy: Diagnosis of epilepsy. Frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VANFLYTA - UAW TRUST

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is FLT3 internal tandem duplication (ITD) positive. Vanflyta will be used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VECTIBIX - UAW TRUST

Products Affected

- Vectibix INJ 100MG/5ML, 400MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer: Diagnosis of advanced or metastatic colorectal cancer. One of the following: (1) Relapsed, refractory, or disease progression on one chemotherapy regimen containing fluoropyrimidine [eg, Xeloda (capecitabine), 5-FU/Adrucil (fluorouracil)] or Eloxatin (oxaliplatin) or Camptosar (irinotecan), or (2) use in combination with either FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or FOLFIRI (fluorouracil, leucovorin, and irinotecan), or (3) intolerance to intensive therapy (eg, FOLFOX, FOLFIRI), or (4) used as monotherapy in patients not appropriate for intensive therapy. Tumor expresses wild-type KRAS gene and wild type NRAS gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VENCLEXTA - UAW TRUST

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	Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Acute Myeloid Leukemia (AML): One of the following: 1) Diagnosis of newly diagnosed AML. Used in combination with azacitidine, or decitabine, or low-dose cytarabine. One of the following: age 60 years or older OR comorbidities that preclude use of intensive induction chemotherapy. 2) Diagnosis of relapsed/refractory acute myeloid leukemia (AML). Relapse is greater than or equal to 12 months from most recent disease remission. Venclexta therapy to be given in combination with the patients previous initial successful induction regimen (e.g., azacitidine, decitabine, low-dose cytarabine, etc.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Chronic Heart Failure (CHF) (initial): Diagnosis of CHF. Patient has an ejection fraction less than 45 percent. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. One of the following: A) Patient was hospitalized for heart failure within the last 6 months, or B) Patient used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months. Trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), 2) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), or 3) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)], B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone].
Age Restrictions	N/A
Prescriber Restrictions	CHF (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CHF (initial, reauth): plan year
Other Criteria	CHF (reauth): Documentation of positive clinical response to therapy.

VERZENIO - UAW TRUST

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced, Recurrent, or Metastatic Breast Cancer: Diagnosis of advanced, recurrent, or metastatic breast cancer. Disease is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), OR b) used in combination with Faslodex (fulvestrant) OR c) used as monotherapy and disease has progressed following endocrine therapy and patient has already received at least one prior chemotherapy regimen. Early Breast Cancer: Diagnosis of early breast cancer at high risk of recurrence. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Used in combination with one of the following endocrine therapies: 1) tamoxifen or 2) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VIGABATRIN - UAW TRUST

Products Affected

- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. CPS: Trial and failure, contraindication, or intolerance (TF/C/I) to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)].

VITRAKVI - UAW TRUST

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.). Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.). Disease is without a known acquired resistance mutation [e.g., TRKA G595R, G623R, G696A, F617L]. Disease is one of the following: metastatic or unresectable. One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VIZIMPRO - UAW TRUST

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is advanced or metastatic. Disease is positive for one of the following epidermal growth factor receptor (EGFR) mutations: exon 19 deletion or exon 21 L858R substitution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VONJO - UAW TRUST

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has been diagnosed with one of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. One of the following: a) Patient has a platelet count below 50 x 10^9/L, OR b) Both of the following: i) Patient has a platelet count greater than or equal to 50 x 10^9/L, AND ii) History of no response or loss of response to one prior JAK inhibitor (e.g., Jakafi or Inrebic).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

VORICONAZOLE INJECTION

Products Affected

- Voriconazole INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
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	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A

VOTRIENT - UAW TRUST

Products Affected

- Votrient

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal Cell Carcinoma (RCC): Diagnosis of RCC. Soft tissue sarcoma (STS): Diagnosis of advanced STS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

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	Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of two or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Dificid (fidaxomicin), 2) Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A

VRAYLAR - UAW TRUST

Products Affected

- Vraylar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia or diagnosis of bipolar disorder or diagnosis of major depressive disorder (MDD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days. Schizophrenia and manic/mixed episodes of bipolar disorder - documented inadequate response or intolerance to aripiprazole and at least one other atypical antipsychotic (e.g., olanzapine, quetiapine, risperidone, ziprasidone). Depressive episodes of bipolar disorder - documented inadequate response or intolerance to olanzapine and quetiapine. MDD - medication is being used as adjunctive therapy to antidepressants and documented inadequate response or intolerance to both of the following atypical antipsychotics: aripiprazole and quetiapine ER.

WELIREG - UAW TRUST

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of von Hippel-Lindau (VHL) disease. Patient requires therapy for one of the following: a) renal cell carcinoma (RCC), b) central nervous system (CNS) hemangioblastoma, or c) pancreatic neuroendocrine tumor (pNET). Patient does not require immediate surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XALKORI - UAW TRUST

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): Diagnosis of advanced, metastatic or recurrent NSCLC. Anaplastic Large Cell Lymphoma (ALCL): Diagnosis of systemic ALCL. Disease is relapsed or refractory. Tumor is anaplastic lymphoma kinase (ALK)-positive. Inflammatory Myofibroblastic Tumor (IMT): Diagnosis of IMT. Tumor is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XATMEP - UAW TRUST

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 anti-inflammatory 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	ALL: Prescribed by or in consultation with a hematologist or oncologist. pJIA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	ALL: plan year. pJIA (initial, reauth): plan year
Other Criteria	ALL: Approve for continuation of prior therapy if within the past 180 days. pJIA (reauth): Documentation of positive clinical response to therapy

XCOPRI - UAW TRUST

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Xeljanz tab/Xeljanz XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Xeljanz tab/Xeljanz XR tab: Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Xeljanz tab/Xeljanz XR tab: Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, etanercept, adalimumab). Xeljanz tab/Xeljanz XR tab: Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA/PJIA/PsA/AS (init): 6 mo. UC (init): 4 mo. RA/PJIA/PsA/AS/UC (reauth): plan year.

Other Criteria	Xeljanz: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, etanercept, adalimumab). RA, PsA, AS, PJIA (Initial, Reauth): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. UC (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).

XENPOZYME

Products Affected

- Xenpozyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of acid sphingomyelinase deficiency (ASMD). Disease confirmed by ONE of the following: a) Molecular genetic testing confirms biallelic pathogenic variants in the SMPD1 (sphingomyelin phophodiesterase-1) gene OR b) Residual acid sphingomyelinase activity that is less than 10% of controls (in peripheral blood lymphocytes or cultured skin fibroblasts). Patient has non-central nervous system manifestations of ASMD.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a metabolic disease specialist or geneticist.
Coverage Duration	Initial, Reauth: Plan Year.
Other Criteria	Reauth: Documentation of positive clinical response to therapy.

XEOMIN - UAW TRUST

Products Affected

- Xeomin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. Upper limb spasticity (ULS) (init): Diagnosis of upper limb spasticity. Chronic Sialorrhea (CS) (init): Diagnosis of chronic sialorrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications (init, reauth): 3 months
Other Criteria	CD, blepharospasm, ULS (reauth): Confirmed improvement in symptoms with initial treatment. At least 3 months have elapsed or will have elapsed since the last treatment. CS (reauth): Confirmed improvement in symptoms with initial treatment. At least 4 months have elapsed or will have elapsed since the last treatment.

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	Carcinoid syndrome diarrhea (Initial): Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months AND used in combination with SSA therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	Initial: 6 months, Reauth: plan year
Other Criteria	Carcinoid syndrome diarrhea (Reauthorization): Documentation of positive clinical response to therapy (e.g., reduction in bowel movement frequency, improvement in stool consistency, improvement in quality of life, etc.) AND will continue to be used in combination with SSA therapy.

XGEVA - UAW TRUST

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prevention of skeletal-related events in patients with multiple myeloma (MM) and bone metastases from solid tumors (BMST): One of the following: 1) Diagnosis of multiple myeloma OR 2) Diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. Tumor is unresectable or surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM) (initial): Diagnosis of hypercalcemia of malignancy and refractory to bisphosphonate therapy. Hypercalcemia of malignancy (reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	GCTB, Hypercalcemia of malignancy (initial): Prescribed by or in consultation with an oncologist
Coverage Duration	MM/BMST: plan year. GCTB: 6 mo. HCM (all): 2 mo.
Other Criteria	Giant cell tumor of bone : Approve for continuation of prior therapy if within the past 180 days.

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Traveler's Diarrhea (TD) (only 200 mg strength): Diagnosis of traveler's diarrhea. Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis of Hepatic Encephalopathy (HE) (only 550 mg strength): Used for the prophylaxis of hepatic encephalopathy recurrence. Trial and failure, contraindication, or intolerance to lactulose. Treatment of HE: Diagnosis of HE. Used for the treatment of HE. Trial and failure, contraindiation, or intolerance to lactulose. Irritable Bowel Syndrome with Diarrhea (Initial) (only 550 mg strength): Diagnosis of irritable bowel syndrome with diarrhea (IBS-D). Trial and failure, contraindication or intolerance to an antidiarrheal agent (e.g., loperamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TD: 14 days (one treatment course). HE (Prophylaxis, Tx): plan year. IBS-D (initial/reauth): 2 wks
Other Criteria	IBS-D Reauthorization (only 550 mg strength): Patient experiences IBS-D symptom recurrence.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (Initial): Diagnosis of moderate to severe persistent allergic asthma. Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 700 IU/mL for patients 12 years of age and older OR greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL for patients 6 years to less than 12 years of age. Positive skin test or in vitro reactivity to a perennial aeroallergen. Chronic Spontaneous Urticaria (CSU) (Previously Chronic Idiopathic Urticaria) (Initial): Diagnosis of CSU (previously chronic idiopathic urticaria). Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (Previously Nasal Polyps) (Initial): Diagnosis of CRSwNP (previously nasal polyps). Asthma (Reauthorization): Documentation of positive clinical response to therapy (e.g., reduction in number of asthma exacerbations, improvement in forced expiratory volume in 1 second (FEV1), or decreased use of rescue medications). Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications. CSU (Reauthorization): Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline. CRSwNP (Reauthorization): Documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NCS: 0-3 scale]).
Age Restrictions	N/A
Prescriber Restrictions	Asthma (Init): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CSU (Init): Prescribed by or in consultation with an allergist/immunologist, or dermatologist. CRSwNP (Init): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist.

Coverage Duration	Asthma, Init: 6 mo, Reauth: plan year. CSU, Init: 3 mo, Reauth: 6 mo. CRSwNP, Init/Reauth: plan year
Other Criteria	Asthma (Initial): One of the following: a) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR b) Prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with one of the following, unless there is a contraindication or intolerance to these medications: 1) one maximally-dosed combination inhaled corticosteroid/long-acting beta2-agonist [eg, Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)] or 2) Both of the following: a)one high-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] and b) one additional asthma controller medication {e.g., leukotriene receptor antagonist, long-acting beta2-agonist [eg, Foradil (formoterol fumarate), Serevent (salmeterol xinafoate)], tiotropium}. CSU (Initial): Persistent symptoms (itching and hives) with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a history of contraindication or intolerance to H1 antihistamines. Patient has tried and had an inadequate response or intolerance or contraindication to one of the following additional therapies: H1-antihistamine, Hydroxyzine, H2-antagonist (e.g., famotidine, cimetidine), Leukotriene receptor antagonist (e.g., montelukast). CRSwNP (Initial): Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (e.g., fluticasone, mometasone). CRSwNP (Previously Nasal Polyps) (Initial/Reauth): Used in combination with another agent for chronic rhinosinusitis with nasal polyps.

XOSPATA - UAW TRUST

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). AML is FMS-like tyrosine kinase (FLT3) mutation-positive. Disease is relapsed or refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XPOVIO - UAW TRUST

Products Affected

- Xpovio
- Xpovio 100 Mg Once Weekly
- Xpovio 40 Mg Once Weekly
- Xpovio 40 Mg Twice Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Once 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	Multiple Myeloma (MM): Diagnosis of multiple myeloma. Patient has received at least one prior therapy (e.g., lenalidomide, bortezomib, daratumumab, pomalidomide). Used in combination with one of the following: bortezomib and dexamethasone, daratumumab and dexamethasone, or carfilzomib and dexamethasone. Relapsed/Refractory Multiple Myeloma (RRMM): Diagnosis of relapsed or refractory multiple myeloma (RRMM). Patient has received at least four prior therapies (e.g., lenalidomide, bortezomib, daratumumab, pomalidomide). Disease is refractory to all of the following: 1) Two proteasome inhibitors (e.g., bortezomib, carfilzomib), 2) Two immunomodulatory agents (e.g., lenalidomide, thalidomide), and 3) An anti-CD38 monoclonal antibody (e.g. daratumumab). Used in combination with dexamethasone. Diffuse large B-cell lymphoma (DLBCL): Diagnosis of one of the following: 1) Relapsed or refractory DLBCL not otherwise specified OR 2) Relapsed or refractory DLBCL arising from follicular lymphoma. Patient has previously received at least two lines of systemic therapy (e.g., CHOP: cyclophosphamide, doxorubicin, vincristine, and prednisone plus rituximab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XTANDI - UAW TRUST

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic castration-resistant or recurrent prostate cancer (mCRPC): Diagnosis of castration-resistant or castration-recurrent prostate cancer. Disease is metastatic. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or 2) Patient received bilateral orchiectomy. Non-metastatic CRPC: Diagnosis of prostate cancer. Disease is non-metastatic, castration-resistant or recurrent. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or 2) Patient received bilateral orchiectomy. Metastatic castration-sensitive prostate cancer (mCSPC): Diagnosis of metastatic castration-sensitive prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND Trial and failure, contraindication, or intolerance to both of the following: 1) modafinil, AND 2) methylphenidate-based stimulant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.

YONDELIS - UAW TRUST

Products Affected

- Yondelis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Leiomyosarcoma/liposarcoma: Diagnosis of unresectable or metastatic leiomyosarcoma or liposarcoma. Patient has received at least one prior anthracycline-containing regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

YONSA - UAW TRUST

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of prostate cancer. One of the following: 1) Disease is metastatic, 2) Disease is regional node positive (e.g., N1), or 3) Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT). Used in combination with methylprednisolone. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin]) or 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

YUFLYMA

Products Affected

- Yuflyma 1-pen Kit
- Yuflyma 2-pen Kit
- Yuflyma 2-syringe Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): Diagnosis (Dx) of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate (MTX), leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): Dx of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA)(Initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (PSO)(Initial): Dx of moderate to severe chronic PSO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD)(Initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine (6-MP), azathioprine, corticosteroid (eg, prednisone), MTX.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, JIA (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (Initial): Prescribed by or in consultation with a dermatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (Initial): 12 wks. Other uses (Initial): 6 months. All uses (reauth): plan year.

Other Criteria	Ulcerative Colitis (UC) (Initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-MP, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Hidradenitis suppurativa (HS) (Initial): Dx of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Documentation of positive clinical response to therapy. Plaque psoriasis (Reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

ZALTRAP - UAW TRUST

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Use in combination with one of the following: FOLFIRI (fluorouracil, leucovorin, irinotecan) regimen OR irinotecan. Trial and failure to an Eloxatin (oxaliplatin)-containing regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZEJULA - UAW TRUST

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: advanced epithelial ovarian cancer, advanced fallopian tube cancer, or advanced primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to first-line platinum-based chemotherapy (e.g., cisplatin, carboplatin). Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days

ZELBORAF - UAW TRUST

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient is positive for BRAF V600 mutation. Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZEPOSIA - UAW TRUST

Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). Ulcerative Colitis (UC) (init): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: 1) Trial and failure, contraindication, or intolerance to two of the following: Formulary adalimumab product (ie, Humira, Cyltezo, Yuflyma), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) For continuation of prior therapy if within the past 180 days.
Age Restrictions	N/A
Prescriber Restrictions	UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS: Plan Year. UC (init): 12 weeks. UC (reauth): Plan Year.
Other Criteria	UC (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

ZEPZELCA - UAW TRUST

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	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Used for the reduction of the recurrence of Clostridium difficile infection (CDI). Used in combination with antibacterial drug treatment for CDI [e.g., oral Vancocin (vancomycin), Flagyl (metronidazole), or Dificid (fidaxomicin)]. Patient has one or more of the following risk factors associated with CDI recurrence: one or more prior episodes of CDI in the previous 6 months, immunocompromised, chronic dialysis, inflammatory bowel disease, or continued use of non-CDI antimicrobials after diagnosis of CDI and/or after CDI treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or gastroenterologist.
Coverage Duration	14 days
Other Criteria	N/A

ZOKINVY

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with one of the following: i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m2 and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZOLINZA - UAW TRUST

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least two systemic therapies (e.g., extracorporeal photopheresis [ECP], systemic retinoids, interferons, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZTALMY - UAW TRUST

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene. Trial and failure, contraindication, or intolerance to two formulary anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine).
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZYDELIG - UAW TRUST

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease has relapsed or is refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZYKADIA - UAW TRUST

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	Diagnosis of metastatic, recurrent, or advanced non-small cell lung cancer (NSCLC), tumor is anaplastic lymphoma kinase (ALK)-positive or ROS1-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZYNLONTA - UAW TRUST

Products Affected

- Zynlonta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: 1) Diffuse large B-cell lymphoma (DLBCL), 2) DLBCL arising from low-grade lymphoma, or 3) High-grade B-cell lymphoma. Disease is one of the following: a) relapsed or b) refractory. Patient has received at least two prior systemic therapies (e.g., rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, dexamethasone, cisplatin, cytarabine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

ZYNYZ - UAW TRUST

Products Affected

- Zynyz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Merkel cell carcinoma (MCC). Disease is metastatic or recurrent locally advanced.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 180 days.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 10MG, 2MG/ML, 50MG
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Ambisome
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 270MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 400MG/100ML; 200MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML

- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 10.69GM/L; 300MG/100ML; 570MG/100ML; 70GM/L; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Arformoterol Tartrate
- Azathioprine INJ
- Azathioprine TABS 50MG
- Baclofen INJ 20000MCG/20ML, 40MG/20ML, 500MCG/ML
- Bleomycin Sulfate INJ
- Blincyto
- Budesonide SUSP
- Calcitriol CAPS
- Calcitriol INJ 1MCG/ML
- Calcitriol ORAL SOLN
- Cladribine
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix 8/14

- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 8/10
- Clinimix E 8/14
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Deferoxamine Mesylate
- Dextrose 5%
- Dextrose 5%/nacl 0.9%
- Diphenhydramine Hcl INJ 50MG/ML
- Diphenhydramine Hydrochloride INJ
- Doxercalciferol
- Doxorubicin Hcl INJ 2MG/ML, 50MG
- Doxorubicin Hydrochloride INJ 10MG, 2MG/ML
- Dronabinol
- Engerix-b
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG

- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML, 500MCG/10ML, 50MCG/ML
- Floxuridine INJ
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Formoterol Fumarate NEBU
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Furosemide INJ
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heparin Sodium INJ 1000UNIT/ML
- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Heplisav-b
- Ibandronate Sodium INJ
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%

- Ipratropium Bromide/albuterol Sulfate
- Lactated Ringers INJ 3MEQ/L; 109MEQ/L; 28MEQ/L; 4MEQ/L; 130MEQ/L
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Lidocaine Hcl INJ 0.5%, 1%, 1.5%, 100MG/5ML, 2%, 4%, 50MG/5ML
- Lidocaine Hydrochloride INJ 1%, 2%
- Mitigo
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nabi-hb INJ 312UNIT/ML
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Paricalcitol CAPS
- Pentamidine Isethionate INHALATION SOLR
- Perforomist
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Potassium Chloride INJ 10MEQ/100ML, 10MEQ/50ML, 20MEQ/100ML, 20MEQ/50ML, 2MEQ/ML, 40MEQ/100ML
- Potassium Chloride/dextrose INJ 5%; 10MEQ/L, 5%; 20MEQ/L

- Potassium Chloride/sodium Chloride INJ 20MEQ/L; 0.45%, 20MEQ/L; 0.9%, 40MEQ/L; 0.9%
- 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
- Procalamine
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Sodium Chloride INJ 0.9%, 3%, 5%
- 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
- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML

- Tyvaso
- Tyvaso Refill
- Tyvaso Starter
- Ventavis
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Zoledronic Acid INJ 4MG/100ML, 4MG/5ML, 5MG/100ML

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.

ANTIDEPRESSANTS - UAW TRUST

Products Affected

- Auvelity
- Desvenlafaxine Er TB24 100MG, 50MG
- Fetzima
- Fetzima Titration Pack
- Fluoxetine Dr
- Fluoxetine Hydrochloride TABS 60MG
- Fluvoxamine Maleate Er
- Trintellix
- Viibryd Starter Pack
- Vilazodone Hydrochloride

Details

Criteria	Step 1: Any one of the following single ingredient oral generics: citalopram tablet or solution, desvenlafaxine succinate ER (25 mg, 50 mg, 100 mg) tablet, duloxetine (20 mg, 30 mg, 40 mg, 60 mg) capsule, escitalopram tablet or solution, fluoxetine 20 mg or 40 mg capsules, fluoxetine 20mg/5mL solution, fluvoxamine tablets, paroxetine IR tablet, sertaline tablet or solution, venlafaxine IR tablet. Step 2: Desvenlafaxine ER 50 mg or 100 mg tablet, Fetzima, generic fluoxetine 60 mg tablet, generic fluoxetine 90 mg DR capsule, generic fluvoxamine ER capsules, Trintellix, generic vilazodone, brand Viibryd Kit, Auvelity. Approve of continuation of prior therapy. Step does not apply for requests for Auvelity, Fetzima, Trintellix, or generic vilazodone or brand Viibryd kit if a member has symptoms of suicidal ideation.

ATYPICAL ANTIPSYCHOTICS - UAW TRUST

Products Affected

- Aripiprazole Odt
- Clozapine Odt
- Olanzapine Odt
- Olanzapine/fluoxetine
- Paliperidone Er
- Risperidone Odt
- Secuado
- Versacloz

Details

Criteria	Step 1: Any two of the following oral generics: aripiprazole (tablet or solution), clozapine tablet, olanzapine tablet, quetiapine (IR or ER tablet), risperidone (tablet or solution), ziprasidone capsule. Step 2: Generic aripiprazole ODT, generic clozapine ODT, generic olanzapine ODT, generic olanzapine-fluoxetine, generic paliperidone ER, generic risperidone ODT, Versacloz, Secuado. Approve for continuation of prior therapy.

BPH DRUGS - UAW TRUST

Products Affected

- Dutasteride CAPS
- Dutasteride/tamsulosin Hydrochloride

Details

Criteria	Step 1: Any one of the following generics: alfuzosin ER, finasteride, tamsulosin. Step 2: Generic dutasteride, generic dutasteride-tamsulosin.

COMT INHIBITOR THERAPY

Products Affected

- Ongentys

Details

Criteria	Step 1: Generic entacapone. Step 2: Ongentys

DOAC THERAPY - UAW TRUST

Products Affected

- Pradaxa CAPS

Details

Criteria	Step 1: Xarelto or Eliquis. Step 2: Pradaxa.

DPP4 - INHIBITORS - UAW TRUST

Products Affected

- Kombiglyze Xr
- Nesina
- Onglyza

Details

Criteria	Step 1: Any one of the following: Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, Tradjenta. Step 2: Kombiglyze XR, Nesina, Onglyza.

FEBUXOSTAT - UAW TRUST

Products Affected

- Febuxostat

Details

Criteria	Step 1: Generic allopurinol. Step 2: Generic febuxostat.

INSULIN OTHER - UAW TRUST

Products Affected

- Novolin 70/30 INJ 30UNIT/ML; 70UNIT/ML
- Novolin 70/30 Flexpen
- Novolin 70/30 Flexpen Relion
- Novolin 70/30 Relion
- Novolin N
- Novolin N Flexpen
- Novolin N Flexpen Relion
- Novolin N Relion
- Novolin R
- Novolin R Flexpen
- Novolin R Flexpen Relion
- Novolin R Relion

Details

Criteria	Step 1: Any one of the following: Humulin 70/30, Humulin 70/30 Kwikpen, Humulin N, Humulin N Kwikpen, Humulin R, Humulin R U-500, Humulin R U-500 Kwikpen. Step 2: Novolin 70/30 Flexpen, Novolin 70/30, Novolin N Flexpen, Novolin N, Novolin R Flexpen, Novolin R.

OSTEOPOROSIS - UAW TRUST

Products Affected

- Risedronate Sodium TABS 150MG, 35MG, 5MG
- Risedronate Sodium Dr

Details

Criteria	Step 1: Any one generic of the following: alendronate (tablet or solution) or ibandronate. Step 2: Generic risedronate

RAPID - ACTING INSULINS - UAW TRUST

Products Affected

- Apidra
- Apidra Solostar
- Novolog
- Novolog Flexpen
- Novolog Flexpen Relion
- Novolog MIX 70/30
- Novolog MIX 70/30 Prefilled Flexpen
- Novolog MIX 70/30 Prefilled Flexpen Relion
- Novolog MIX 70/30 Relion
- Novolog Penfill
- Novolog Relion

Details

Criteria	Step 1: Any one of the following: Humalog Junior Kwikpen, Humalog KwikPen, Humalog Mix75/25 KwikPen, Humalog Mix 50/50 KwikPen, Humalog Mix 50/50, Humalog Mix 75/25, Humalog (100 unit/mL). Step 2: Apidra SoloStar, Apidra (100 unit/mL), Novolog Flexpen, Novolog Mix 70/30, Novolog PenFill, Novolog Mix 70/30 Prefilled Flexpen, Novolog (100 unit/mL).

RENIN INHIBITORS - UAW TRUST

Products Affected

- Aliskiren

Details

Criteria	Step 1: Any two of the following oral generics: amlodipine-olmesartan, amlodipine-valsartan-hydrochlorothiazide, amlodipine-valsartan, candesartan, candesartan-hydrochlorothiazide, irbesartan, irbesartan-hydrochlorothiazide, losartan, losartan-hydrochlorothiazide, olmesartan, olmesartan-amlodipine, olmesartan-amlodipidine-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan, telmisartan-amlodipine, telmisartan-hydrochlorothiazide, valasartan, valsartan-hydrochlorothiazide. Step 2: Aliskiren

SHORT ACTING INHALED BRONCHODILATORS - UAW TRUST

Products Affected

- Proair Respiclick
- Xopenex Hfa

Details

Criteria	Step 1: Ventolin or albuterol sulfate HFA (generic Proair, by manufacturer: Teva, NDC: 00093-3174-**, by manufacturer: Perrigo, NDC: 45802-0088-**, or by manufacturer: Lupin, NDC: 68180-0963-**, generic Proventil, by manufacturer: Par, NDC: 00254-1007-**, by manufacturer Sandoz 00781-7296**, by manufacturer: Civica, NDC: 72572-0014-**, by manufacturer: Hikma, NDC: 00054-0742-**, or by manufacturer: Cipla, NDC: 69097-0142-**). Step 2: ProAir Respiclick, Xopenex HFA.

TOPICAL IMMUNOMODULATOR THERAPY

Products Affected

- Pimecrolimus

Details

Criteria	Step 1: Any two of the following formulary topical agents: desonide ointment, Ala-Cort 2.5% or hydrocortisone 2.5% cream, hydrocortisone 2.5% ointment, generic aug betamethasone 0.05%, fluocinonide 0.05%, tacrolimus ointment. Step 2: generic pimecrolimus

TRIPTANS - UAW TRUST

Products Affected

- Almotriptan
- Almotriptan Malate
- Eletriptan Hydrobromide
- Frovatriptan Succinate

Details

Criteria	Step 1: Any one of the following oral generics: rizatriptan (tablet or ODT), sumatriptan tablet, naratriptan tablet, zolmitriptan (tablet or ODT). Step 2: Almotriptan, Eletriptan, Frovatriptan.

TUDORZA THERAPY

Products Affected

- Tudorza Pressair

Details

Criteria	Step 1: One from the following: Spiriva Respimat, Brand Spiriva Handihaler, or generic tiotropium capsule, AND Incruse. Step 2: Tudorza