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
2024 Plan Year
Updated 12/1/2024

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_UAW24PAST_C FVNR 1124

ABIRATERONE

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 120 days.

ABRAXANE

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 120 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

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 adults.
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, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) for continuation of prior therapy if within the past 120 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, Orencia (abatacept), Xeljanz (tofacitinib), OR 2) for continuation of prior therapy if within the past 120 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 [e.g., 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, SJIA, GCA (reauth): Patient demonstrates positive clinical response to therapy.

ACTEMRA SC

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, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), OR 2) for continuation of prior therapy if within the past 120 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, Orencia (abatacept), Rinvoq/Rinvoq LQ, Xeljanz (tofacitinib), OR 2) for continuation of prior therapy if within the past 120 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	All indications (reauth): Patient demonstrates positive clinical response to therapy.

ACTHAR - UAW TRUST

Products Affected

- Acthar
- Acthar Gel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Infantile spasm: Diagnosis of infantile spasm. Multiple Sclerosis (MS): Diagnosis of relapsing MS. Patient is experiencing an acute exacerbation. One of the following: patient is currently on a disease modifying relapsing remitting MS agent (e.g., glatiramer, dimethyl fumarate, fingolimod), patient 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). Nephrotic syndrome (initial): Diagnosis of nephrotic syndrome. Documented proteinuria greater than or equal to 3 grams/24 hours and this is not due to uremia of idiopathic type or lupus erythematous. Patient has failed a systemic corticosteroid (e.g., prednisone, IV methylprednisolone) in the past 30 days. Dermatologic diseases (initial): Diagnosis of severe erythema multiforme, Stevens-Johnson syndrome. Ophthalmic diseases (initial): Diagnosis of one of the following: keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation. Rheumatic disorders (initial): Diagnosis of one of the following: psoriatic arthritis, rheumatoid arthritis (including juvenile rheumatoid arthritis), ankylosing spondylitis. Patient is experiencing an acute exacerbation. Patient is currently on a disease-modifying antirheumatic drugs (DMARD) (e.g., methotrexate, sulfasalazine) or has a documented contraindication or intolerance to 2 or more DMARDs. Collagen diseases (initial): Diagnosis of systemic lupus erythematous or systemic dermatomyositis (polymyositis). Respiratory diseases (initial): Diagnosis of symptomatic sarcoidosis. Serum sickness (initial): Diagnosis of serum sickness. All indications except infantile spasm (initial): Chart notes detailing the outcomes of the most recent trial in the past 30 days 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	MS: 3 wks. Infantile spasms: 4 wks. All Others initial: 4 wks. All Others Reauth: 3 mos.
Other Criteria	All indications (initial and reauthorization): Provider confirms that the patient does not have one of the following contraindications to therapy: scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction. Reauthorization for all indications other than infantile spasms or MS: Documentation of 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: Patient demonstrates positive clinical response to therapy.

ADCETRIS

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 120 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

ADSTILADRIN

Products Affected

- Adstiladrin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Muscle Invasive Bladder Cancer (NMIBC): Diagnosis of high-risk, NMIBC. One of the following: a) Tumor is carcinoma in situ (CIS), or b) Ta/T1 high grade disease. Patient is not eligible for or has elected not to undergo cystectomy. 4 Patient has received an adequate course of Bacillus Calmette Guérin (BCG) therapy defined as the administration of at least 5 of 6 doses of an initial induction course plus one of the following: a) At least two of three doses of maintenance therapy, or b) At least two of six doses of a second induction course. Tumor is BCG unresponsive as defined by one of the following: a) Persistent disease following adequate BCG therapy, b) Disease recurrence after an initial tumor-free state following adequate BCG therapy, or c) T1 disease following a single induction course of BCG. The patient has had all resectable disease (Ta and T1 components) removed. The patient does not have extra-vesical (i.e., urethra, ureter, or renal pelvis), muscle invasive (T2-T4), or metastatic urothelial carcinoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

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. Patient has greater than or equal to 4 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), g) Lisinopril. Chronic Migraines (CM) (initial): Diagnosis of CM. Patient has 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), h) Lisinopril. 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 demonstrates positive clinical response to therapy. 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. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Patient has 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 demonstrates positive clinical response to therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

AKEEGA

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer. Disease is all of the following: a) metastatic, b) castration-resistant, and c) deleterious or suspected deleterious BRCA-mutated (BRCAm). Used in combination with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is anaplastic lymphoma kinase (ALK)-positive. One of the following: 1) Disease is one of the following: a) Recurrent, b) Advanced, or c) Metastatic, or 2) Used as adjuvant treatment following tumor resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ALIQOPA

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 120 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): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

ALUNBRIG

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 120 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): Patient demonstrates 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): Patient demonstrates positive clinical response to therapy. SWD (Reauth): Patient demonstrates positive clinical response to therapy.

ARZERRA

Products Affected

- Arzerra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Refractory Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia (CLL). Disease is refractory to both of the following: fludarabine and alemtuzumab. Previously Untreated Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia (CLL). Patient is previously untreated for CLL. Patient is not an appropriate candidate for fludarabine-based therapy. Used in combination with chlorambucil. Recurrent or Progressive Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia (CLL). Disease is one of the following: recurrent or progressive. Used for the extended treatment of patients who are in complete or partial response after at least two lines of therapy [e.g., Imbruvica (ibrutinib), VEN+G (venetoclax + obinutuzumab)]. Relapsed Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia (CLL). Disease has relapsed. Used in combination with fludarabine and cyclophosphamide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: Plan year
Other Criteria	All uses: Approve for continuation of prior therapy if within the past 120 days.

AUGTYRO

Products Affected

- Augtyro CAPS 40MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) advanced, or b) metastatic. Disease is ROS1-positive. Solid Tumors: Diagnosis of solid tumors. Disease is positive for neutrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1). Disease is one of the following: A) Locally advanced, B) Metastatic, or C) Unresectable (including cases where surgical resection is likely to result in severe morbidity).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: Plan year.
Other Criteria	All indications: Approve for continuation of prior therapy if within the past 120 days.

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. One of the following: 1) Patient has unresectable, recurrent, or metastatic disease after failure on one approved therapy (e.g., imatinib, sunitinib, dasatinib, regorafenib, ripretinib) 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 120 days.

AZACITIDINE

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 120 days.

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). One of the following: Locally advanced or metastatic. Presence of fibroblast growth factor receptor (FGFR) 3 genetic alterations. Disease has progressed on or after at least one line of 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 120 days.

BAVENCIO

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	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days

BELEODAQ

Products Affected

- Beleodaq

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

BENDAMUSTINE

Products Affected

- Belrapzo
- Bendamustine Hydrochloride
- Bendeka
- Vivimusta

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 120 days.

BENLYSTA

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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): Patient demonstrates positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SLE, Lupus Nephritis (initial, reauth): 6 months
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

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 120 days.

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

BEVACIZUMAB (NON-PREFERRED)

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 (5-FU)]-irinotecan-based therapy, Fluoropyrimidine [eg, capecitabine, floxuridine, fluorouracil (5-FU)]-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. 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	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. 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. All indications (except ARMD and Macular Edema): Trial and failure or intolerance to both Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). All uses: Approve for continuation of prior therapy if within the past 120 days.

BEVACIZUMAB PREFERRED

Products Affected

- Mvasi
- Zirabev

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 (5-FU)]-irinotecan-based therapy, Fluoropyrimidine [eg, capecitabine, floxuridine, fluorouracil (5-FU)]-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. 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	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. 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 120 days.

BEXAROTENE

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 120 days.

BORTEZOMIB

Products Affected

- Bortezomib INJ 1MG, 2.5MG, 3.5MG

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 120 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

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 120 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): Patient demonstrates 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 demonstrates positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Achalasia (Reauth): Patient demonstrates 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. Patient demonstrates positive clinical response to therapy.

BRAFTOVI

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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). Non-Small Cell Lung Cancer: Diagnosis of metastatic NSCLC. Patient is positive for BRAF V600 mutation. Used in combination with Mektovi (binimetinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days

BRIVIACT

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 120 days.

BRONCHITOL

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Patient has passed the Bronchitol Tolerance Test (BTT).
Age Restrictions	CF (initial): Patient is 18 years of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	CF (initial): 6 months. CF (reauth): Plan year.
Other Criteria	CF (reauth): Patient demonstrates positive clinical response to therapy.

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed, refractory, or progressive. 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. Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Patient has received at least two prior lines of 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 120 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

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 120 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 120 days.

CAMCEVI

Products Affected

- Camcevi

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. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Prostate Cancer: Approve for continuation of prior therapy.

CAPLYTA

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: asenapine, aripiprazole, paliperidone, olanzapine, quetiapine (IR or ER), risperidone, or ziprasidone. 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 120 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

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Type 1 Gaucher disease
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): Patient demonstrates positive clinical response to therapy.

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

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, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 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, Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR for continuation of prior therapy if within the past 120 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 [ie, Enbrel or Formulary adalimumab product], IL-17 [ie, Cosentyx (secukinumab)], IL-23 [ie, Stelara or Skyrizi], JAK [ie, Xeljanz/Xeljanz XR or Rinvoq/Rinvoq LQ], PDE4 [ie, Otezla (apremilast)], T-cell [ie, Orencia], OR for continuation of prior therapy if within the past 120 days. Ankylosing Spondylitis (AS): Dx of active AS. TF/C/I to two agents from the following different mechanisms of action: TNF [ie, Enbrel or Formulary adalimumab product], IL-17 [ie, Cosentyx], JAK [ie, Rinvoq or Xeljanz/Xeljanz XR], OR for continuation of prior therapy if within the past 120 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 [ie, Enbrel or Formulary adalimumab product], IL-17 [ie, Cosentyx], IL-23 [ie, Stelara or Skyrizi], PDE4 [ie, Otezla]. 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. All indications (reauth): Patient demonstrates positive clinical response to therapy.

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

CLOBAZAM

Products Affected

- Clobazam

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 120 days.

CLONIDINE ER

Products Affected

- Clonidine Hydrochloride Er TB12

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

COLUMVI

Products Affected

- Columvi

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: 1) Relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified (DLBCL, NOS), or 2) Large B-cell lymphoma (LBCL) arising from follicular lymphoma. Patient has had two or more lines of systemic therapy (e.g., chemotherapy). Patient will receive pretreatment with Gazyva (obinutuzumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

CORLANOR - UAW TRUST

Products Affected

- Corlanor
- Ivabradine Hydrochloride

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 ivabradine - 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 ivabradine - LVEF of less than or equal to 35 percent prior to initiation of ivabradine 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

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 (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. 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. 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. 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 non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis, HS (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. All indications (Reauth): Patient demonstrates positive clinical response to therapy.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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

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: 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. TIO: Prescribed by or in consultation with an oncologist or endocrinologist.
Coverage Duration	XLH, TIO (Initial, Reauth): Plan Year
Other Criteria	XLH (Reauth): Patient demonstrates of positive clinical response to therapy. TIO (Reauth): Patient demonstrates of positive clinical response to therapy

CYLTEZO

Products Affected

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

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.
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. PsO, HS (Initial): Prescribed by or in consultation with a dermatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. UV (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). Uveitis (UV) (Initial): Dx of non-infectious uveitis classified as intermediate, posterior, or panuveitis. RA, PJIA, PsA, AS, PsO, CD, HS, UV (Reauth): Patient demonstrates positive clinical response to therapy. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient has 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: Patient demonstrates positive clinical response to therapy.

CYRAMZA

Products Affected

- Cyramza

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

DANYELZA

Products Affected

- Danyelza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

DARZALEX

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 120 days.

DARZALEX FASPRO

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 120 days.

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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): Patient demonstrates 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

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): Patient demonstrates positive clinical response to therapy. ANC greater than 1.5 x 10^9/L.

DEGARELIX

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 120 days.

DEXRAZOXANE

Products Affected

- Dexrazoxane

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic breast cancer (initial): Diagnosis of metastatic breast cancer. Patient has received a cumulative doxorubicin dose of at least 300 mg/m2.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Metastatic breast cancer (reauth): Patient does not show evidence of progressive disease while on dexrazoxane therapy. Patient is continuing to receive doxorubicin or doxorubicin-based therapy.

DIHYDROERGOTAMINE NASAL

Products Affected

- Dihydroergotamine Mesylate SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

DOPTELET

Products Affected

- Doptelet

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. Patient has chronic liver disease and is scheduled to undergo a procedure. Baseline platelet count is less than 50,000/mcL. Chronic Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TPPP: 1 month. ITP (initial, reauth): Plan year
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy.

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 120 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): Patient demonstrates 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: Patient demonstrates 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	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): One of the following: a) Patient is 6 years of age or older but less than 12 years of age AND Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications: 1) Medium-dose inhaled corticosteroid (eg, greater than 100 – 200 mcg fluticasone propionate equivalent/day) and additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) OR 2) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg], Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]) OR b) Patient is 12 years of age or older AND Patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications: 1) High-dose ICS [e.g., greater than 500 mcg fluticasone propionate equivalent/day] and additional asthma controller medication [e.g., LTRA (eg, montelukast), LABA (eg, salmeterol), LAMA (eg, tiotropium)] OR 2) One max-dosed combination ICS/LABA product (eg, Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta (fluticasone/vilanterol)).
Age Restrictions	AD (initial): Patient is 6 months of age or older. EoE (initial): Patient is 1 year 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 or allergist/immunologist. COPD (init, reauth): Prescribed by or in consultation with a pulmonologist.
Coverage Duration	CRSwNP, EoE (Init/Reauth): Plan year. Asthma, AD, PN, COPD (Init): 6 mo, (reauth): Plan yr.
Other Criteria	Atopic Dermatitis (AD) (init): Diagnosis (dx) of moderate-to-severe 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 min 30-day supply (14-day supply for topical corticosteroids [TCS]), 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 TCS, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. Eosinophilic esophagitis (EoE) (initial): Dx of EoE. Patient weighs at least 15 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, EoE, PN, COPD (reauth): Patient demonstrates positive clinical response to therapy. Chronic rhinosinusitis with nasal polyposis (CRSwNP) (initial): Dx of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 mo of treatment with an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. EA, CDA (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP. Prurigo nodularis (PN) (init): Diagnosis of PN. Trial and failure, contraindication, or intolerance to one medium or higher potency topical corticosteroid. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells/mcL at baseline. Patient is receiving both of the following therapies: A LAMA [eg, Spiriva (tiotropium), Incruse (umeclidinium)] AND a LABA [eg, Serevent (salmeterol), arformoterol, formoterol]. Post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70 while on therapy. Patient has had one of the following within the past 12 mo: At least two exacerbations where systemic corticosteroids

	[intramuscular, intravenous, or oral (eg, prednisone)] were required at least once OR COPD-related hospitalization. COPD (reauth): Patient continues to receive both of the following therapies: a LAMA [eg, Spiriva (tiotropium), Incruse (umeclidinium)] AND a LABA [eg, Serevent (salmeterol), arformoterol, formoterol].

ELAHERE

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 120 days.

ELELYSO

Products Affected

- Elelyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Type 1 Gaucher disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ELIGARD

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	30 mg, 45 mg: Approve for continuation of prior therapy. All other strengths: Approve for continuation of prior therapy if within the past 120 days.

ELREXFIO

Products Affected

- Elrexfio

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 120 days.

ELZONRIS

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 120 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. Patient has greater than or equal to 4 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), g) Lisinopril. 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. Patient has 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), h) Lisinopril. 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 demonstrates positive clinical response to therapy. Medication will not be used in combination with another injectable CGRP inhibitor. EM, CM (reauth): Patient demonstrates positive clinical

	response to therapy. 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): Patient demonstrates positive clinical response to therapy.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 120 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	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

ENDARI

Products Affected

- Endari
- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. Patient has had 2 or more painful sickle cell crises within the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Sickle cell disease (initial, reauth): plan year
Other Criteria	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.

ENHERTU

Products Affected

- Enhertu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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). Solid Tumors: Diagnosis of Solid Tumors. Disease is one of the following: unresectable or metastatic. Disease is HER2-positive. Patient has received a prior systemic therapy (e.g., chemotherapy) and have no satisfactory alternative treatment options.
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 120 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: Patient demonstrates a positive clinical response to therapy. 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): Patient demonstrates positive clinical response to therapy.

ENTYVIO

Products Affected

- Entyvio

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, Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) For continuation of prior therapy if within the past 120 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: 1) TF/C/I to two of the following: Formulary adalimumab product, Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR 2) for continuation of prior therapy if within the past 120 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): Patient demonstrates positive clinical response to therapy.

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

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 120 days.

EPKINLY

Products Affected

- Epkinly

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: 1) Relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, 2) Diffuse large B-cell lymphoma (DLBCL) arising from indolent lymphoma, or 3) High grade B-cell lymphoma. Patient has had two or more lines of 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 120 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. Patient demonstrates 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.

ERBITUX

Products Affected

- Erbitux

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

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-metastatic castration-resistant prostate cancer (NM-CRPC): Diagnosis of non-metastatic, castration-resistant (chemical or surgical) or 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], Firmagon [degarelix]) OR 2) Patient received a bilateral orchiectomy. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic, castration-sensitive or naive prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex [goserelin], 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 120 days

ERLOTINIB

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 120 days.

EVEROLIMUS

Products Affected

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

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 120 days.

EVEROLIMUS SOLUTION

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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	TSC Associated Partial-Onset Seizures: Dx of TSC associated partial-onset seizures. Used as adjunctive therapy. All uses: Approve for continuation of prior therapy if within the past 120 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): Patient demonstrates positive clinical response to therapy. 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

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 120 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 120 days. Documented inadequate response or intolerance to aripiprazole and at least one other atypical antipsychotic (e.g., olanzapine, quetiapine, risperidone, ziprasidone).

FARYDAK

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 120 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. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age, and b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100 - 200 mcg fluticasone propionate equivalent/day) AND Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR ii) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/salmeterol 50mcg], Symbicort [budesonide 80mcg/formoterol 4.5mcg], Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]), OR 2) Both of the following: a) Patient is 12 years of age or older, and b) 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 ICS (eg, greater than 500 mcg fluticasone propionate equivalent/day) and 2) additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, 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	N/A
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: Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, 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, oral hydrocodone at a dose of greater than or equal to 60mg/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

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 120 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): Patient demonstrates positive clinical response to therapy.

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 or solar 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

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 120 days.

FRUZAQLA

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy, and B) Anti-VEGF biological therapy (e.g., bevacizumab, ramucirumab). One of the following: A) Patient does not have RAS wild type tumors, OR B) Both of the following: a) Patient has RAS wild type tumors, AND b) Trial and failure, contraindication, or intolerance to both of the following: 1) An anti-EGFR biological therapy (e.g., panitumumab, cetuximab), and 2) One of the following: i) Trifluridine/tipiracil or ii) Regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

FYARRO

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 120 days.

GAMASTAN

Products Affected

- Gamastan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Hepatitis A: Excluded if patient has clinical manifestations of hepatitis A or exposure to hepatitis A for more than 2 weeks previously. Measles: Excluded if patient is receiving measles vaccine at the same time.
Required Medical Information	For prophylaxis before or soon after exposure to Hepatitis A. Measles: For use in susceptible individuals exposed to measles fewer than 6 days previously. Varicella: For passive immunization against varicella in immunosuppressed patients. Varicella zoster immune globulin (human) vaccine is not available. Rubella: For pregnant women who are exposed or susceptible to rubella who will not consider a therapeutic abortion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

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): Patient demonstrates positive clinical response to therapy.

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

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 120 days

GAZYVA

Products Affected

- Gazyva

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): One of the following: Diagnosis of CLL or SLL. Follicular Lymphoma (FL): One of the following: 1) All of the following: A) Diagnosis of FL B) Both of the following: Used in combination with bendamustine followed by Gazyva monotherapy C) Relapsed or refractory to a rituximab-containing regimen OR 2) All of the following: A)Diagnosis of stage II bulky, III or IV FL, B)Patient has not been treated with prior therapy C)Both of the following: will be used in combination with chemotherapy until patient has at least achieved a partial remission and followed by Gazyva monotherapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For continuation of prior therapy if used within the last 120 days

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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: Patient demonstrates positive clinical response. Patient has not had liver transplant.

GLP1 - UAW TRUST

Products Affected

- Bydureon Bcise
- Byetta
- Liraglutide
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity
- Victoza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Diabetes Mellitus (DM): 1) Diagnosis of type 2 DM, OR 2) Trial of one product from any of the following drugs/classes: alpha-glucosidase inhibitors, amylin analogs, biguanides, Cycloset (bromocriptine 0.8 mg), DPP-4 inhibitors, DPP-4 inhibitor combinations, glycemic agents (e.g., glucagon), insulins, meglitinides, SGLT2 inhibitors, SGLT2 inhibitor combinations, sulfonylureas, or thiazolidinediones.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

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.

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].

HALAVEN

Products Affected

- Eribulin Mesylate
- Halaven

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 recurrent or metastatic breast cancer. Liposarcoma: Diagnosis of unresectable or metastatic liposarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

HARVONI (EM)

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 120 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

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. Trial and failure or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp) or approve for continuation of prior therapy if within the past 120 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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 (UV) (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. UV (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, PsA, AS, PsO, CD, HS, UV (Reauth): Patient demonstrates positive clinical response to therapy. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient has 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: Patient demonstrates positive clinical response to therapy.

HYDROXYPROGESTERONE

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 120 days.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ICATIBANT

Products Affected

- Icatibant Acetate
- Sajazir

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

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 120 days.

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, B) Patient is not a candidate for or patient declines intensive induction therapy, C) Used for post induction therapy following response to low intensity induction therapy, or D) Used for consolidation therapy as continuation of low-intensity regimen used for induction.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IGALMI

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 120 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): Patient demonstrates positive clinical response to therapy. SJIA (Reauth): Patient demonstrates of positive clinical response to therapy.

IMATINIB

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 120 days.

IMBRUVICA

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 120 days.

IMDELLTRA

Products Affected

- Imdelltra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of extensive stage small cell lung caner (ES-SCLC). Disease has progressed on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IMFINZI

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 120 days.

IMJUDO

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 120 days.

INFLIXIMAB (NON - PREFERRED)

Products Affected

- 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 one of the following: immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine) OR corticosteroid (eg, prednisone). CD, FCD, UC, RA, AS, PsA, plaque psoriasis, sarcoidosis (Initial): Trial and failure or intolerance to Inflectra or Avsola. All indications (Reauth): Patient demonstrates positive clinical response to therapy.

INFLIXIMAB PREFERRED

Products Affected

- Avsola
- Inflectra

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). All indications (Reauth): Patient demonstrates 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.Using hormones to change characteristics to align with gender expression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

INSULIN - LIKE GROWTH FACTOR

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial therapy: IGF-1 deficiency: Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion: Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH. Reauthorization: Patient demonstrates positive clinical response to therapy. Both of the following: (1) Expected adult height is not obtained and (2) Documentation of expected adult height goal
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: plan year
Other Criteria	N/A

INTRON - A

Products Affected

- Intron A INJ 10000000UNIT, 18000000UNIT, 50000000UNIT

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 120 days.

IRESSA

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ISOTRETINOIN

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	(initial): Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy OR diagnosis of treatment resistant acne. Trial and failure, contraindication or intolerance to an adequate trial (at least 6 weeks) on two of the following conventional therapy regimens: a) topical retinoid or retinoid-like agent [eg, Retin-A/Retin-A Micro (tretinoin),] b) oral antibiotic [eg, Ery-Tab (erythromycin), Minocin (minocycline)], c) topical antibiotic with or without benzoyl peroxide [eg, Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]. Retreatment (Reauthorization): After greater than or equal to 2 months off therapy, persistent or recurring severe recalcitrant nodular acne is still present.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: Retreatment - 6 months
Other Criteria	N/A

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): Patient demonstrates positive clinical response to therapy.

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

IVIG (PREFERRED)

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. 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. Pt does not meet criteria for Part B or patient is in a long-term care facility. 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 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: teriflunomide, interferon beta-1b, interferon beta-1a, glatiramer acetate, natalizumab, dimethyl fumarate, 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.

IWILFIN

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of high-risk neuroblastoma (HRNB). Patient has shown at least a partial response to prior multiagent, multimodality therapy. Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of 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., Calquence (acalabrutinib), Brukinsa (zanubrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Patient has received treatment for CLL/SLL with both of the following therapies: a) BTK inhibitor therapy [e.g., Calquence (acalabrutinib), Brukinsa (zanubrutinib)], and b) B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

JEMPERLI

Products Affected

- Jemperli

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

JEVTANA

Products Affected

- Jevtana

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. Disease is castration-resistant or castration-recurrent. Disease is metastatic. Used in combination with prednisone. Documented disease progression during or after previous treatment with docetaxel-based 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 120 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.

JYLAMVO

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neoplastic diseases: Diagnosis of one of the following: A) acute lymphoblastic leukemia (ALL), B) mycosis fungoides (cutaneous T-cell lymphoma), or C) relapsed or refractory non-Hodgkin lymphomas. Rheumatoid arthritis (RA) (initial): Diagnosis of RA. Psoriasis (initial): Diagnosis of severe psoriasis.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Neoplastic diseases: Plan Year. RA, Psoriasis (initial, reauth): Plan Year.
Other Criteria	Neoplastic diseases: Approve for continuation of prior therapy if within the past 120 days. RA, Psoriasis (reauth): Patient demonstrates positive clinical response to therapy.

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 is new to therapy or 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): Patient demonstrates 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

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 120 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): Patient demonstrates positive clinical response to therapy.

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Lysosomal acid lipase deficiency: Diagnosis of lysosomal acid lipase deficiency (e.g., LAL-D, Wolman Disease, Cholesteryl ester storage disease). Diagnosis was confirmed by one of the following: a) enzymatic blood test (e.g., dried blood spot test) demonstrating a deficiency of LAL enzyme activity, OR b) genetic testing for mutations in the Lipase A, Lysosomal Acid Type (LIPA) gene.
Age Restrictions	N/A
Prescriber Restrictions	Initial, reauth: Prescribed by or in consultation with one of the following: specialist experienced in the treatment of inborn errors of metabolism, gastroenterologist, or lipidologist
Coverage Duration	Initial: 6 months. Reauth: Plan year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

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. Serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. 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: Patient demonstrates 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

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 120 days.

KIMMTRAK

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 120 days.

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 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, NOMID (reauth): Patient demonstrates positive clinical response to therapy.

KISQALI

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 120 days

KISQALI - FEMARA PACK

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 120 days

KORLYM

Products Affected

- Korlym
- Mifepristone TABS 300MG

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

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 120 days.

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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). Colorectal Cancer (CRC): Diagnosis of CRC. 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 120 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	Plan Year
Other Criteria	Gout (reauth): Patient demonstrates a positive clinical response to therapy

KYNMOBI

Products Affected

- Kynmobi

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

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 120 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

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 120 days.

LAZCLUZE

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) Recurrent, b) Advanced, or c) Metastatic. Disease is positive for one of the following: a) Epidermal growth factor receptor (EGFR) exon 19 deletion or b) EGFR exon 21 L858R mutation. Used in combination with Rybrevant (amivantamab-vmjw).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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) 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

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 120 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

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 120 days.

LIBERVANT

Products Affected

- Libervant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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
- Fentanyl PT72
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadone Hydrochloride CONC
- Methadone Hydrochloride Intensol
- Morphine Sulfate Er CP24 100MG, 10MG, 120MG, 20MG, 30MG, 45MG, 50MG, 60MG, 75MG, 80MG, 90MG
- 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

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 120 days.

LOQTORZI

Products Affected

- Loqtorzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of nasopharyngeal carcinoma (NPC). Disease is one of the following: A) metastatic, or B) recurrent and locally advanced. One of the following: A) Both of the following: 1) Used as first line treatment, and 2) Used in combination with cisplatin and gemcitabine, or B) Disease has progressed on or after a platinum 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 120 days.

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

LUMOXITI

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

LUNSUMIO

Products Affected

- Lunsumio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Follicular Lymphoma: Diagnosis of follicular lymphoma. Disease is one of the following: relapsed or refractory. Patient has received two or more lines of systemic therapy (e.g., rituximab, bendamustine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

LUPRON DEPOT

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 120 days. Prostate Cancer (30 mg, 45 mg): Approve for continuation of prior therapy.

LUPRON DEPOT PED

Products Affected

- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Lupron Depot-ped (6-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 (ini, reauth): plan yr.
Other Criteria	CPP (Reauthorization): Documentation of bone age monitoring (eg, radiographic imaging).

LYNPARZA (TABLETS)

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: Diagnosis of metastatic castration-resistant prostate cancer. One of the following: 1) Both of the following: a) Presence of deleterious or suspected deleterious homologous recombination repair (HRR) gene mutations and b) Disease has progressed following prior treatment with one of the following: i) enzalutamide (Xtandi), or ii) abiraterone (e.g., Zytiga, Yonsa), OR 2) All of the following: a) Presence of deleterious or suspected deleterious BRCA-mutation, b) Used in combination with abiraterone (e.g., Zytiga, Yonsa), and c) Used in combination with prednisone or prednisolone. 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 has had bilateral orchiectomy. All indications: Approve for continuation of prior therapy if within the past 120 days.

LYTGOBI

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

MARGENZA

Products Affected

- Margenza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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: 1) One of the following: a) Diagnosis of chronic hepatitis C (CHC), or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of CHC, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) 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

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	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MEGESTROL TAB

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	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

MEKINIST

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 120 days.

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Patient is positive for BRAF V600 mutation. Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. 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 120 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 TABS 200MG

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

MIGLUSTAT

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate Type 1 Gaucher disease. Patient is unable to receive enzyme replacement therapy due to one of the following conditions: allergy or hypersensitivity to enzyme replacement therapy, poor venous access, or unavailability of enzyme replacement therapy (e.g. Cerezyme, VPRIV).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MODAFINIL

Products Affected

- Modafinil TABS

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): Patient demonstrates positive clinical response to therapy. SWD (Reauth): Patient demonstrates positive clinical response to therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with therapy. Depression (reauth): Patient demonstrates positive clinical response to therapy. Used as adjunctive therapy.

MONJUVI

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

MRESVIA

Products Affected

- Mresvia

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 their lifetime. One of the following: a) Age greater than or equal to 75 years, or b) Both of the following: 1) Age 60 through 74 years, and 2) Patient is at increased risk of severe RSV disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

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: Patient demonstrates 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 demonstrates positive clinical response to therapy. Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (reauth): Patient demonstrates positive clinical response to therapy. Treatment duration of Myfembree has not exceeded a total of 24 months.

MYLOTARG

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 120 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): Patient demonstrates 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

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 120 days.

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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: a) Dx of advanced or metastatic breast cancer, b) Disease is human epidermal growth factor receptor 2 (HER2)-positive, c) Patient has received two or more prior anti-HER2 based regimens (e.g., trastuzumab + pertuzumab + docetaxel, ado-trastuzumab emtansine, etc.), and d) Used in combination with capecitabine, OR 2) Both of the following: a) Diagnosis of Stage IV (M1) breast cancer, and b) One of the following: i) Hormone receptor-positive, (HER2)-negative disease in patients who have already received a CDK4/6 inhibitor therapy, or ii) 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 120 days

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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) Used as primary therapy or maintenance therapy OR 3) Both of the following: a) Patient is a transplant candidate and b) One of the following: Patient has symptomatic disease following response to primary myeloma therapy or response or stable disease following autologous or allogeneic 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 120 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): Patient demonstrates 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

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 120 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 (eg, prednisone) within the past 12 months or Patient has had a prior asthma-related hospitalization within the past 12 months. One of the following: 1) Patient is 6 years of age or older but less than 12 years of age AND Patient is currently being treated with both a medium-dose inhaled corticosteroid (ICS) (eg, greater than 100 – 200 mcg fluticasone propionate equivalent/day) and additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR one medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg], Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]), unless there is a contraindication or intolerance to these medications, OR 2) Patient is 12 years of age or older AND Patient is currently being treated with both a high dose ICS (eg, greater than 500 mcg fluticasone propionate equivalent/day) and additional asthma controller medication [eg, LTRA (eg, montelukast), LABA (eg, salmeterol), LAMA (eg, 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.
Age Restrictions	N/A
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	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 (eg, 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 (ie, corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (eg, prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. 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 (eg, 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 (eg, prednisone) or cytotoxic/immunosuppressive therapy (eg, hydroxyurea, cyclosporine, imatinib). Severe asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an ICS (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Patient demonstrates positive clinical response to therapy.

NUEDEXTA

Products Affected

- Nuedexta

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

NULOJIX

Products Affected

- Nulojix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transplant: For prophylaxis of acute organ rejection of transplanted renal (kidney) allograft. Patient is EBV seropositive.
Age Restrictions	N/A
Prescriber Restrictions	Transplant: Prescribed by a kidney transplant specialist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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. Patient has greater than or equal to 4 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), g) Lisinopril. 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 demonstrates positive clinical response to therapy. Medication will not be used in combination with another oral CGRP inhibitor. Preventive Treatment of EM (reauth): Patient demonstrates positive clinical response to therapy. 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

Products Affected

- Ocrevus
- Ocrevus Zunovo

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) 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 120 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): Patient demonstrates positive clinical response to therapy.

OCTREOTIDE

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 profuse watery 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): Patient demonstrates positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications: 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 120 days.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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): Patient demonstrates 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

OGSIVEO

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

OJEMDA

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 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 120 days.

OJJAARA

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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 demonstrates positive clinical response to therapy. 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

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 120 days.

OPDIVO

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 120 days.

OPDUALAG

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 120 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 or punctal plugs
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

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. 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. TF/C/I to one of the following: Enbrel (etanercept), Formulary adalimumab product, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 days. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis 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. One of the following: TF/C/I to Enbrel (etanercept), Formulary adalimumab product, Xeljanz (tofacitinib), OR for continuation of prior therapy if within the past 120 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. TF/C/I to one of the following: Enbrel (etanercept), Formulary adalimumab product, Cosentyx (secukinumab), Stelara (ustekinumab), Skyrizi (risankizumab-rzaa), Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib), or Otezla (apremilast), OR for continuation of prior therapy if within the past 120 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, PsA (reauth): Patient demonstrates positive clinical response to therapy.

ORENCIA SC

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. 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. TF/C/I to one of the following: Enbrel (etanercept), Formulary adalimumab product, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 days. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis 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. One of the following: TF/C/I to Enbrel (etanercept), Formulary adalimumab product, Rinvoq/Rinvoq LQ, Xeljanz (tofacitinib), OR for continuation of prior therapy if within the past 120 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. TF/C/I to one of the following: Enbrel (etanercept), Formulary adalimumab product, Cosentyx (secukinumab), Stelara (ustekinumab), Skyrizi (risankizumab-rzaa), Xeljanz/Xeljanz XR (tofacitinib), Rinvoq/Rinvoq LQ (upadacitinib), or Otezla (apremilast), OR for continuation of prior therapy if within the past 120 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	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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 demonstrates positive clinical response to therapy. 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.
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	CF (reauth): Patient demonstrates positive clinical response to therapy.

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): Patient demonstrates positive clinical response to therapy. 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

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, b) Patient is a postmenopausal woman, or c) Patient is a premenopausal woman treated with ovarian ablation/suppression. 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 120 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

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. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. 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. 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	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

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) (initial): Diagnosis of NK.
Age Restrictions	N/A
Prescriber Restrictions	NK (initial): Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	NK (initial, reauth): 8 Weeks
Other Criteria	NK (reauth): One of the following: 1) Both of the following: a) Provider attests patient is being treated for disease recurrence (e.g., new corneal damage following prior corneal healing), and b) Provider attests patient has not experienced treatment failure (e.g., patient has not experienced corneal healing after a previous course of Oxervate), OR 2) Provider attests treatment is for an eye that has not previously been treated with Oxervate.

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): Patient demonstrates positive clinical response to therapy. Patient has not received a liver transplant.

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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): Patient demonstrates positive clinical response to therapy. Patient will continue to have phenylalanine blood levels measured periodically during therapy.

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

PEMETREXED

Products Affected

- Pemetrexed
- Pemetrexed Disodium
- Pemfexy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-squamous Non-Small Cell Lung Cancer (NSCLC): Diagnosis of non-squamous NSCLC. One of the following: 1) All of the following: a) Disease is metastatic, b) Used in combination with pembrolizumab and platinum chemotherapy (e.g., cisplatin, carboplatin), and c) Disease does not have EGFR or ALK genomic tumor aberrations, OR 2) Both of the following: a) Disease is locally advanced or metastatic and b) Used in combination with cisplatin for initial treatment, OR 3) 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 4) All of the following: a) Disease is recurrent, b) Disease is metastatic, and c) Used as a single agent after prior chemotherapy. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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

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 120 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.

PERJETA

Products Affected

- Perjeta

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

PHESGO

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 120 days.

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. 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 120 days.

PIRFENIDONE

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): Patient demonstrates 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

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. One of the following: 1) Trial and failure, contraindication or intolerance to one of the following: a) immunomodulatory agent [eg, Revlimid (lenalidomide)] or b) proteasome inhibitor [eg, Velcade (bortezomib)], OR 2) Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome. Kaposi sarcoma (KS): One of the following: 1) Both of the following: a) Diagnosis of AIDS-related KS and b) One of the following: i) Patient has failed highly active antiretroviral therapy (HAART) [e.g., Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide), Dovato (dolutegravir/lamivudine), Triumeq (dolutegravir/abacavir/lamivudine)], or ii) Patient is currently being treated with antiretroviral therapy (ART), 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 120 days.

PORTRAZZA

Products Affected

- Portrazza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 120 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

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
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 120 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) Heterozygous familial hypercholesterolemia (HeFH), B) Atherosclerotic cardiovascular disease (ASCVD), OR C) Primary Hyperlipidemia (HLD). HoFH (initial): dx of homozygous familial hypercholesterolemia (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 55 mg/dL with ASCVD. (2) LDL-C greater than or equal to 70 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 are within normal limits. AND One of the following: i) Pt has been receiving at least 12 weeks of one maximally-tolerated statin tx, ii) 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, iii) patient has a contraindication to all statins, or iv) 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) OR patient has inability to take other lipid lowering tx (e.g., statin, ezetimibe). HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering therapy (eg statin, ezetimibe) at

	the maximally tolerated dose or pt has documented inability to take other lipid-lowering therapy (eg statin, ezetimibe). HoFH (reauth): Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) OR pt has an inability to take other lipid-lowering therapy (e.g., statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy.

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	Cytomegalovirus (CMV) Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT): Used for prophylaxis of CMV infection and disease, patient is a CMV-seropositive recipient [R+] of an allogeneic HSCT, and patient is unable to take oral therapy. 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

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 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

PROGRAF (IV)

Products Affected

- Prograf INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney), cardiac (heart), or hepatic (liver) 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 120 days. Unable to take oral tacrolimus.

PROLEUKIN

Products Affected

- Proleukin

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 metastatic, relapsed, or unresectable Stage IV RCC. Melanoma: Diagnosis of metastatic, unresectable, Stage III melanoma. RCC, Melanoma: Good neurologic or ambulatory performance status (ie, 0 or 1 by Eastern Cooperative Oncology Group, 70-100% by Karnofsky scoring system). Adequate organ function (ie, heart, lungs, kidneys) as determined by all of the following: normal cardiac stress test results, Forced expiratory volume in 1 second (FEV1) greater than 2 L on pulmonary function tests, serum creatinine concentration less than or equal to 1.5 mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of therapy if within the past 120 days.

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic thrombocytopenic purpura (ITP) (initial): Diagnosis of one of the following: persistent ITP, chronic ITP or 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. ITP (reauthorization): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Chronic Hepatitis C-associated thrombocytopenia (initial): Diagnosis of chronic hepatitis C-associated thrombocytopenia. One of the following: planning to initiate and maintain interferon-based treatment or currently receiving interferon-based treatment. First-line for severe aplastic anemia (SAA): Diagnosis of SAA. Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy with any equine antithymocyte globulin plus cyclosporine, alemtuzumab, or high dose cyclophosphamide). Used in combination with standard immunosuppressive therapy (e.g., Atgam [antithymocyte globulin equine] and cyclosporine). Patient meets at least two of the following: 1) absolute neutrophil count less than 500/mcL, 2) platelet count less than 20,000/mcL, 3) absolute reticulocyte count less than 60,000/mcL. Refractory SAA (initial): Diagnosis of refractory SAA. Patient has a platelet count less than 30,000/mcL. SAA (reauthorization): Patient demonstrates positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1stline SAA:6mo.HepC (init):3mo.RefractSAA(init):16wk.ITP,HepC(reauth),RefractSAA(reauth):plan yr
Other Criteria	ITP (initial): Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or

	splenectomy. Chronic Hepatitis C-associated thrombocytopenia (Reauthorization): One of the following criteria: For patients that started treatment with eltrombopag prior to initiation of treatment with interferon, eltrombopag will be approved when both of the following are met: currently on antiviral interferon treatment for treatment of chronic hepatitis C and documentation that patient reached threshold platelet count that allows initiation of antiviral interferon therapy with eltrombopag treatment by week 9. OR for patients that started treatment with eltrombopag while on concomitant treatment with interferon, eltrombopag will be approved based on the following criterion: currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA: Trial and failure, contraindication, or intolerance to at least one course of immunosuppressive therapy (eg, Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine).

PURIXAN

Products Affected

- Purixan

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: History of contraindication or intolerance to generic mercaptopurine tablets OR patient is unable to swallow tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

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: Patient demonstrates positive clinical response to therapy.

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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.

QULIPTA

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraine (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 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), g) Lisinopril. Chronic Migraines (CM) (initial): Diagnosis of CM. Patient has 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), h) Lisinopril. 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 demonstrates positive clinical response to therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

RADICAVA

Products Affected

- Edaravone
- 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.

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.

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, MDS/MPN-RS-T (reauth): Patient demonstrates a positive clinical response to therapy.

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)
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 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 diagnoses: A) Heterozygous familial hypercholesterolemia (HeFH), B) Atherosclerotic cardiovascular disease (ASCVD), OR C) Primary Hyperlipidemia (HLD). HoFH (initial): dx of homozygous familial hypercholesterolemia (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 55 mg/dL with ASCVD. (2) LDL-C greater than or equal to 70 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 are within normal limits. AND One of the following: i) Pt has been receiving at least 12 weeks of one max-tolerated statin tx, ii) 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, iii) patient has a contraindication to all statins, or iv) 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) OR patient has inability to take other lipid lowering tx (e.g., statin, ezetimibe). HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering therapy (e.g., statin, ezetimibe)

	at the maximally tolerated dose or pt has documented inability to take other lipid-lowering therapy (eg statin, ezetimibe). HoFH (reauth): Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) OR patient has inability to take other lipid lowering tx (e.g., statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy.

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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

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 120 days.

REXULTI - UAW TRUST

Products Affected

- Rexulti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia, Depression: Diagnosis of schizophrenia or diagnosis of major depressive disorder. Documented inadequate response or intolerance to aripiprazole and at least one other atypical antipsychotic [e.g., olanzapine, quetiapine (IR or ER), risperidone]. Agitation associated with dementia due to Alzheimer's disease: Diagnosis of Alzheimer's disease. Patient has a Mini-Mental State Examination (MMSE) score of between 5 and 22 and total score of at least 4 by the agitation/aggression item of the NPI/NPI-NH. Rexulti will not be used on an as needed basis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) 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 120 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): Patient demonstrates 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 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. 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. Patient has signs of inflammation. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, certolizumab pegol). AS, NRAS (init): Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Atopic dermatitis (AD) (init): Dx of moderate to severe 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, 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 ointment. One of the following: 1) Trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent, etc.), OR 2) Patient has a contraindication, intolerance, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent. Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	AD (initial): Patient is 12 years of age or older.
Prescriber Restrictions	RA, PJIA, 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, PJIA, PsA, AS, NRAS, AD, CD, UC (initial): 6 months, (reauth): Plan year.
Other Criteria	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. RA, PJIA, PsA, AS (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, etanercept, adalimumab). RA, PJIA, PsA, AS, NRAS (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). 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) (init): 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-mercaptopurine, aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). CD/UC (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other JAK inhibitors, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine). All indications (reauth): Patient demonstrates positive clinical response to therapy. AD (reauth): Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine). CD/UC (reauth): Not used in combination with other JAK inhibitors, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).

RINVOQ LQ

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Diagnosis of active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. Psoriatic arthritis (PsA) (init): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PJIA, PsA (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). PJIA, PsA (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	PJIA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	PJIA, PsA (init): 6 months, PJIA, PsA (reauth): Plan year.
Other Criteria	PJIA, PsA (reauth): Patient demonstrates positive clinical response to therapy.

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. Trial and failure or intolerance to Ruxience. Rheumatoid arthritis (RA): Diagnosis of moderately to severely active RA. Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). Trial and failure or intolerance to Ruxience. 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. Trial and failure or intolerance to Ruxience. 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 120 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). Trial and failure or intolerance to Ruxience.

ROFLUMILAST

Products Affected

- 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): Patient demonstrates positive clinical response to therapy.

ROMIDEPSIN

Products Affected

- Romidepsin

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 one systemic therapy for the treatment of CTCL [e.g., Trexall (methotrexate), Targretin (bexarotene), cyclophosphamide].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of ovarian cancer, fallopian tube cancer, or 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). Presence of deleterious BRCA-mutation. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer. Presence of deleterious BRCA mutation. History of failure, contraindication, or intolerance to 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 120 days

RUXIENCE

Products Affected

- Ruxience

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. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to one TNF antagonist (eg, adalimumab, etanercept, infliximab). Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). Chronic Lymphocytic Leukemia (CLL): Diagnosis of CLL. Used in combination with fludarabine and cyclophosphamide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	NHL, CLL: plan yr. WG, MPA: 3 months. RA: 1 month.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

RYBREVANT

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days

RYTELO

Products Affected

- Rytelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of myelodysplastic syndrome. Disease is low to intermediate-1 risk. All of the following: a) Hemoglobin less than 10 g/dL, b) Baseline absolute neutrophil count of 1.5 x 10^9/L or greater, and c) Baseline platelet count of 75 x 10^9/L or greater. Both of the following: a) Patient does not have a confirmed mutation with deletion 5q [del(5q)] and b) Patient has not received prior treatment with Revlimid (lenalidomide) or hypomethylating agents (e.g., azacitidine, decitabine). Patient requires 4 or more red blood cell units over 8 weeks. One of the following: a) Previous treatment with an erythropoiesis stimulating agent shows no response, b) Previous treatment with an erythropoiesis stimulating agent shows loss of response, or c) Patient is ineligible for treatment with an erythropoiesis stimulating agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SAFE DISPENSING

Products Affected

- Valrubicin
- 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 120 days.

SANDOSTATIN LAR

Products Affected

- Octreotide Acetate INJ 20MG, 30MG
- 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 profuse watery diarrhea. Carcinoid tumor: Diagnosis of carcinoid tumor. Reauthorization (all except carcinoid tumor): Patient demonstrates 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 120 days.

SARCLISA

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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)] and prescribed medication dose will not exceed 80 mg per day, OR 2) Disease is T315I mutation positive and prescribed medication dose will not exceed 400 mg per day.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SCIG (PREFERRED)

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) Patient demonstrates positive clinical response to therapy and 2) Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect.

SECUADO - UAW TRUST

Products Affected

- Secuado

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia. Patient has a documented difficulty with the use of oral or oral disintegrating tablet (odt) formulations of antipsychotics [e.g., aripiprazole, paliperidone, olanzapine, quetiapine (IR or ER), risperidone).
Age Restrictions	18 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 120 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

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

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): Dx 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, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 days. 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. One of the following: TF/C/I to two agents from the following different mechanisms of action: TNF [ie, Enbrel (etanercept) or Formulary adalimumab product], IL-17 [ie, Cosentyx (secukinumab)], IL-23 [ie, Stelara (ustekinumab) or Skyrizi (risankizumab-rzaa)], JAK [ie, Xeljanz/Xeljanz XR (tofacitinib) or Rinvoq/Rinvoq LQ], PDE4 [ie, Otezla (apremilast)], T-cell [ie, Orencia], OR for continuation of prior therapy if within the past 120 days. Ankylosing Spondylitis (AS) (initial): Dx of active AS. One of the following: TF/C/I to two agents from the following different mechanisms of action: TNF [ie, Enbrel (etanercept) or Formulary adalimumab product], IL-17 [ie, Cosentyx (secukinumab)], JAK [ie, Rinvoq or Xeljanz/Xeljanz XR (tofacitinib)], OR for continuation of prior therapy if within the past 120 days. 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. One of the following: TF/C/I to two of the following: Formulary adalimumab product, Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR for continuation of prior therapy if within the past 120 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	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pulmonary multidrug resistant tuberculosis (MDR-TB), adverse reactions or resistance to standard drugs used to treat MDR-TB, and one of the following: Sirturo is being used in combination with at least 3 other medications to which the patient's MDR-TB isolate has been shown to be susceptible in vitro, or if in vitro testing results are unavailable Sirturo is being used in combination with at least 4 other medications to which the patient's MDR-TB isolate is likely to be susceptible.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 weeks
Other Criteria	N/A

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: Patient demonstrates positive clinical response to therapy.

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML
- 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. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. 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, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): plan year.
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

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. 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. Trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Will be administered as an intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC, CD: 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. Atypical Hemolytic Uremic Syndrome (aHUS) (initial): Diagnosis of 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.
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): Patient demonstrates positive clinical response to therapy. aHUS (reauth): Patient demonstrates positive clinical response to therapy. gMG, NMOSD (reauth): Patient demonstrates positive clinical response to therapy.

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. One of the following: 1) Inadequate response, contraindication, or intolerance to a somatostatin analog (e.g., octreotide, lanreotide) or 2) Clinical rationale provided for preferred treatment with pegvisomant (e.g., comorbid diabetes mellitus is present with acromegaly, IGF-1 levels greater than 900 ng/mL). Acromegaly (Reauth): Patient demonstrates positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acromegaly (Initial, Reauth): plan year
Other Criteria	N/A

SORAFENIB

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: a) follicular carcinoma, b) Hurthle cell carcinoma, also known as oncocytic carcinoma, or c) 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 120 days.

SOTYLIZE

Products Affected

- Sotylize

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ventricular arrhythmias (VA), Atrial Fibrillation/Flutter (AF/AFL): Diagnosis of VA or AF/AFL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	All indications: One of the following: a) Trial and failure or intolerance to generic sotalol tablets OR b) patient is unable to swallow tablets

SPRAVATO

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 120 days.

SPRYCEL

Products Affected

- Dasatinib
- Sprycel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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. All indications (Reauth): Patient demonstrates positive clinical response to therapy.

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

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) Patient has succinate dehydrogenase (SDH) deficient GIST 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 120 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

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. One of the following: 1) History of disease progression on, contraindication, or intolerance to Gleevec (imatinib), Stivarga (regorafenib), or standard dose Qinlock (ripretinib) or 2) Succinate dehydrogenase (SDH)-deficient GIST. Renal Cell Carcinoma (RCC): Diagnosis of RCC. One of the following: 1) Disease has relapsed, 2) both of the following: medically or surgically unresectable tumor and diagnosis of Stage IV disease, 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): Diagnosis of islet cell tumors/progressive pNET.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SYFOVRE

Products Affected

- Syfovre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) as confirmed by one of the following: 1) Fundus photography (e.g. fundus autofluorescence [FAF]), 2) Optical coherence tomography (OCT), or 3) Fluorescein angiography. GA is not secondary to any other conditions (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: Plan Year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

SYLVANT

Products Affected

- Sylvant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multicentric Castleman's disease (MCD): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist or rheumatologist.
Coverage Duration	6 months
Other Criteria	N/A

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: Patient demonstrates positive clinical response to therapy.

SYMPAZAN

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 120 days.

SYNRIBO

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): One of the following: 1) Diagnosis of advanced phase CML with progression to accelerated phase, 2) Diagnosis of chronic phase CML or accelerated phase CML and Trial and failure, contraindication, or intolerance to two prior tyrosine kinase inhibitor therapies [eg, imatinib, Sprycel (dasatinib), Tasigna (nilotinib), Bosulif (bosutinib), Iclusig (ponatinib)], or 3) Diagnosis of post-transplant relapse or refractory chronic 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 120 days.

TABLOID

Products Affected

- Tabloid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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): Patient demonstrates positive clinical response to therapy. Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure.

TAFINLAR

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 120 days.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

TALVEY

Products Affected

- Talvey

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 120 days.

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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). Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR 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 120 days.

TASIGNA

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 120 days.

TASIMELTEON CAPSULE

Products Affected

- 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).

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazarotene GEL
- Tazorac CREA 0.05%

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

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. Subsequent therapy for one of the following: a) EZH2 mutation positive relapsed/refractory disease after two prior therapies, OR b) EZH2 wild-type or unknown relapsed/refractory disease and no 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 120 days.

TECENTRIQ

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 120 days.

TECVAYLI

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 120 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

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 120 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, or 4) One of the following: a) glucocorticoid dosing of at least 30 mg per day, or b) 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 or in consultation with a neurologist. Tardive dyskinesia, Tourette's: Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Plan year.
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Myelodysplastic Syndromes (MDS): Diagnosis of MDS. Disease is one of the following: relapsed or refractory. MDS is IDH1 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 120 days.

TIVDAK

Products Affected

- Tivdak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

TOLVAPTAN (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

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.

TORPENZ

Products Affected

- Torpenz

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 120 days.

TRASTUZUMAB (NON-PREFERRED)

Products Affected

- Herceptin INJ 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. All indications: Trial and failure or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp) or approve for continuation of prior therapy if within the past 120 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TRASTUZUMAB PREFERRED

Products Affected

- Kanjinti
- Trazimera

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 120 days.

TRELSTAR

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 one of the following: a) Any brand Lupron formulation, OR b) Eligard. 22.5 mg: Approve for continuation of prior therapy. All other strengths: Approve for continuation of prior therapy if within the past 120 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: Patient demonstrates positive clinical response to therapy.

TRODELVY

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

TRUQAP

Products Affected

- Truqap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations. One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant 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 120 days.

TRUSELTIQ

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 120 days.

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

TURALIO

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 120 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

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 disease-modifying therapy for MS (e.g., Gilenya [fingolimod], Avonex [Interferon beta-1a], Betaseron [Interferon beta-1b]), 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 120 days. MS (initial, reauth): Not used in combination with another disease-modifying therapy for MS. MS (reauth): Patient demonstrates positive clinical response to therapy. CD (Initial): TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), 6-mercaptopurine, azathioprine, methotrexate, aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine). TF/C/I to a TNF-inhibitor (eg, adalimumab). CD (initial and reauth): Not used in combination with TNF inhibitors (e.g., adalimumab) or immunosuppressants (eg, 6-MP, azathioprine, cyclosporine, or methotrexate).

TYVASO DPI

Products Affected

- Tyvaso Dpi Institutional Kit
- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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. Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): Diagnosis of PH-ILD. Diagnosis of PH-ILD was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging).
Age Restrictions	N/A
Prescriber Restrictions	PAH, PH-ILD: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, PH-ILD: plan year
Other Criteria	N/A

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: Plan year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Will not be used for preventive treatment of migraine. Medication will not be used in combination with another oral CGRP inhibitor.

UNITUXIN

Products Affected

- Unituxin

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. Used in combination with all of the following: a) Granulocyte-macrophage colony-stimulating factor (GM-CSF) [eg, Leukine (sargramostim)], b) Interleukin-2 (IL-2) [eg, Proleukin (aldesleukin)] and c) 13-cis-retinoic acid (RA) [eg, isotretinoin]. Patient responded to prior first-line multiagent, multimodality therapy (eg, chemotherapy, surgery, stem cell transplant, 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 120 days.

UPTRAVI

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 120 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

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 120 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

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 120 days.

VALTOCO

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

VANDETANIB

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 120 days.

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

VAXCHORA

Products Affected

- Vaxchora

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 active immunization against disease caused by Vibrio cholerae serogroup O1. Patient is traveling to a cholera-affected area. Age 2 through 64 years.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

VECTIBIX

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 120 days.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

VEOPOZ

Products Affected

- Veopoz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of active CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease. Patient has a confirmed genotype of biallelic CD55 loss-of-function mutation. Patient has hypoalbuminemia (serum albumin concentration of less than or equal to 3.2 g/dL). Patient has at least one of the following signs or symptoms within the last six months: abdominal pain, diarrhea, peripheral edema, or facial edema.
Age Restrictions	Initial: Patient is 1 year of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with an immunologist, geneticist, hematologist, or gastroenterologist.
Coverage Duration	Initial, Reauth: Plan Year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy

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): Patient demonstrates positive clinical response to therapy.

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

VIGABATRIN

Products Affected

- Vigabatrin
- Vigadrone
- Vigpoder

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 120 days. CPS: Trial and failure, contraindication, or intolerance (TF/C/I) to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)].

VIGAFYDE

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial and failure, or intolerance to generic vigabatrin powder for oral solution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VIMIZIM

Products Affected

- Vimizim

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis (initial): Diagnosis of Mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome) confirmed by both of the following: a) documented clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.) and b) documented reduced fibroblast or leukocyte GALNS enzyme activity or molecular genetic testing for mutations in the GALNS gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: Plan Year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Presence of solid tumors. 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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is recurrent, advanced, or metastatic. Disease is positive for one of the following epidermal growth factor receptor (EGFR) mutations: a) exon 19 deletion, b) exon 21 L858R substitution, c) S768I, d) L861Q, or e) G719X.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has been diagnosed with one of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, c) Post-essential thrombocythemia myelofibrosis, OR d) Accelerated/blast phase myeloproliferative neoplasm. One of the following: 1) Patient has a platelet count below 50 x 10^9/L, or 2) Patient has a platelet count greater than or equal to 50 x 10^9/L, or 3) Used for treatment of myelofibrosis-associated anemia, or 4) Used for splenomegaly and other disease-related symptoms in one of the following: i) Continued near the start of conditioning therapy of transplant candidates, or ii) Palliation in combination with hypomethylating agents (e.g., azacitidine or decitabine) as bridging therapy prior to transplant, or if not a candidate for 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 120 days.

VORANIGO

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of astrocytoma or oligodendroglioma. Grade 2 disease. Presence of an isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of therapy prior therapy if within the past 120 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

Products Affected

- Pazopanib Hydrochloride
- Votrient

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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 at least 10 consecutive days of 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 120 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.

VYJUVEK

Products Affected

- Vyjuvek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of dystrophic epidermolysis bullosa (DEB). Patient has mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Medication is being used for the treatment of wounds. Medication will be applied by a healthcare professional in either a healthcare professional setting (e.g., clinic) or the home setting. Patient has at least one recurrent or chronic open wound that meets all of the following criteria: a) adequate granulation tissue, b) excellent vascularization, c) no evidence of active wound infection, and d) no evidence or history of squamous cell carcinoma.
Age Restrictions	Initial: Patient is 6 months of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Documentation of positive clinical response to therapy. Wound(s) being treated meet all of the following criteria: a) adequate granulation tissue, b) excellent vascularization, c) no evidence of active wound infection, and d) no evidence or history of squamous cell carcinoma.

VYXEOS

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Therapy related acute myeloid leukemia (t-AML): Newly diagnosed t-AML. Acute myeloid leukemia with myelodysplasia-related changes (AML-MRC): Newly diagnosed AML-MRC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	von Hippel-Lindau (VHL) disease: 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. Advanced Renal Cell Carcinoma (RCC): Diagnosis of advanced renal cell carcinoma. Disease has progressed after treatment with both of the following: a) Programmed death receptor 1 (PD-1) or programmed death ligand 1 (PD-L1) checkpoint inhibitor [e.g.,Keytruda (pembrolizumab), Opdivo (nivolumab), Jemperli (dostarlimab)] and b) Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Inlyta (axitinib), Votrient (pazopanib), Lenvima (lenvatinib), Cabometyx (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 120 days.

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL). Polyarticular juvenile idiopathic arthritis (pJIA) (initial): Diagnosis of active polyarticular juvenile idiopathic arthritis. Trial and failure, contraindication, or intolerance to one nonsteroidal 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	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 120 days. pJIA (reauth): Patient demonstrates positive clinical response to therapy

XCOPRI

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 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, Enbrel, Humira). 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, Humira). 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, Enbrel, Humira). 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). All indications (Reauth): Patient demonstrates positive clinical response to therapy. UC (Reauth): 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: Patient demonstrates 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, lanreotide) 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): Patient demonstrates positive clinical response to therapy.

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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): Patient demonstrates positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
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 120 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): 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): Used for the prophylaxis of hepatic encephalopathy recurrence. One of the following: 1) Trial and failure, contraindication, or intolerance to lactulose OR 2) Add-on treatment to lactulose. Treatment of HE: Diagnosis of HE. Used for the treatment of HE. One of the following: 1) Trial and failure, contraindiation, or intolerance to lactulose OR 2) Add-on treatment to lactulose. Irritable Bowel Syndrome with Diarrhea (Initial): 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: 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. One of the following: A) All of the following: a) Patient is 6 years of age or older but less than 12 years of age, b) pre treatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: 1) Medium-dose inhaled corticosteroid (eg, greater than 100 – 200 mcg fluticasone propionate equivalent/day) AND Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR 2) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg], Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]), OR B) All of the following: a) Patient is 12 years of age or older, b) Pre-treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL, c) 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 ICS/LABA [eg, Advair (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone/vilanterol)] or 2) Both of the following: a) high-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day] and b) additional asthma controller medication {e.g., LTRA, LABA, LAMA [eg, tiotropium]}. Positive skin test or in vitro reactivity to a perennial aeroallergen. 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.
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. IgE-Mediated Food Allergy (Init/Reauth): Prescribed by or in consultation with an allergist/immunologist
Coverage Duration	Asthma,Init:6m,Reauth:PlanYr. CSU,Init:3m,reauth:6m.CRSwNP:PlanYr.Allergy, Init:20wk,Reauth:PlanYr
Other Criteria	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (Previously Nasal Polyps) (Initial): Diagnosis of CRSwNP (previously nasal polyps). Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (eg, fluticasone, mometasone). CRSwNP (Reauthorization): Patient demonstrates positive clinical response to therapy. CRSwNP (Initial/Reauth): Used in combination with another agent for chronic rhinosinusitis with nasal polyps. Asthma (Reauthorization): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, LTRA [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) unless there is a contraindication or intolerance to these medications. CSU (Reauthorization): Patient demonstrates positive clinical response to therapy. IgE-Mediated Food Allergy (Initial): One of the following: A) Both of the following: 1) Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following: a) Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food, b) Positive food specific IgE (greater than or equal to 6 kUA/L), c) Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein, AND 2) Clinical history of IgE Mediated Food Allergy, OR B) Provider attestation that patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods. Used in conjunction with food allergen avoidance. Baseline (pre-Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL. Dosing is according to serum total IgE levels and body weight. IgE-Mediated Food Allergy (Reauth): Patient demonstrates positive clinical response to therapy. Used in conjunction with food allergen avoidance. Dosing will continue to be based on body weight and pretreatment total IgE serum levels. Chronic Spontaneous Urticaria (CSU) (Previously Chronic Idiopathic Urticaria) (Initial): Diagnosis of CSU (previously chronic idiopathic urticaria). Persistent symptoms (itching and hives) with a second generation H1 antihistamine (eg, 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 (eg, famotidine, cimetidine), Leukotriene receptor antagonist (eg, montelukast).

XOLREMDI

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Patient has genotype confirmed variant of CXCR4. Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells/µL.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: immunologist, hematologist, geneticist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: Plan Year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. One of the following: a) Used in combination with azacitidine as low-intensity treatment induction when not a candidate for intensive induction therapy, b) Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen, c) Post-allogeneic hematopoietic cell transplantation and in remission, or d) 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 120 days.

XPOVIO

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate cancer (PC): Diagnosis of prostate cancer. One of the following: 1) Both of the following: a) Disease is castration-resistant or castration-recurrent and b) One of the following: i) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or ii) Patient has had bilateral orchiectomy, or 2) Both of the following: a) Disease is metastatic castration-sensitive and b) One of the following: i) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or ii) Patient has had bilateral orchiectomy, or 3) Disease is non-metastatic castration-sensitive with biochemical recurrence at high risk for metastasis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary Orotic Aciduria (initial): Diagnosis of hereditary orotic aciduria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Hereditary Orotic Aciduria (reauth): Patient demonstrates positive clinical response to therapy.

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.

YERVOY

Products Affected

- Yervoy

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

YONDELIS

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 120 days.

YONSA (XN)

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. Trial and failure or intolerance to Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

YUFLYMA

Products Affected

- Yuflyma 1-pen Kit
- Yuflyma 2-pen Kit
- Yuflyma 2-syringe Kit
- Yuflyma Cd/uc/hs 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.
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. PsO, HS (Initial): Prescribed by or in consultation with a dermatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. UV (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). Uveitis (UV) (Initial): Dx of non-infectious uveitis classified as intermediate, posterior, or panuveitis. RA, PJIA, PsA, AS, PsO, CD, HS, UV (Reauth): Patient demonstrates positive clinical response to therapy. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient has 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: Patient demonstrates positive clinical response to therapy.

ZALTRAP

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 120 days.

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ZEPOSIA

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, Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) For continuation of prior therapy if within the past 120 days.
Age Restrictions	N/A
Prescriber Restrictions	UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS: Plan Year. UC (init): 6 months. UC (reauth): Plan Year.
Other Criteria	UC (reauth): Patient demonstrates positive clinical response to therapy.

ZEPZELCA

Products Affected

- Zepzelca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 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 m^2 and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZOLADEX

Products Affected

- Zoladex

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 or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to Lupron Depot. Endometriosis [Zoladex (3.6 mg strength)]: Treatment of endometriosis. Trial and failure, contraindication, or intolerance to Lupron Depot. Advanced Breast Cancer [Zoladex (3.6 mg strength)]: For the palliative treatment of advanced breast cancer. Endometrial thinning [Zoladex (3.6 mg strength)] For the treatment of dysfunctional uterine bleeding. Used as an endometrial thinning agent prior to endometrial ablation.
Age Restrictions	Endometriosis: 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Prostate Cancer, Advanced Breast Cancer: Approve for continuation of prior therapy if within the past 120 days.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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	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 120 days.

ZURZUVAE

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): One of the following: A) Diagnosis of severe PPD or B) Both of the following: a) Diagnosis of mild to moderate PPD, and b) Trial and failure, contraindication, or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine). Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	PPD: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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 120 days.

ZYNLONTA

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 120 days.

ZYNYZ

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 120 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
- 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
- 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

- Cinacalcet Hydrochloride
- 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%/sodium Chloride 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
- Envarsus Xr
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML, 25MCG/0.5ML, 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
- 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; 4MEQ/L; 130MEQ/L; 28MEQ/L
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- 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%
- Marqibo
- 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 TBDP 4MG, 8MG
- Paricalcitol CAPS
- Pentamidine Isethionate INHALATION SOLR
- 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 Kit
- Tyvaso Starter Kit
- 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
- Fluoxetine Dr
- 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 60 mg tablet, fluoxetine 20mg/5mL solution, fluvoxamine tablets, sertaline tablet or solution, venlafaxine IR tablet, venlafaxine ER capsule. Step 2: Desvenlafaxine ER 50 mg or 100 mg tablet, generic fluoxetine 90 mg DR capsule, generic fluvoxamine ER capsules, Trintellix, generic vilazodone, Auvelity. Approve of continuation of prior therapy. Step does not apply for requests for Auvelity, Trintellix, or generic vilazodone if a member has symptoms of suicidal ideation.

ATYPICAL ANTIPSYCHOTICS - UAW TRUST

Products Affected

- Aripiprazole Odt
- Asenapine Maleate Sl
- Clozapine Odt
- Lurasidone Hydrochloride
- Olanzapine/fluoxetine
- Paliperidone Er
- Risperidone Odt
- Versacloz

Details

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

BPH DRUGS - UAW TRUST

Products Affected

- Dutasteride/tamsulosin Hydrochloride

Details

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

COMT INHIBITOR THERAPY

Products Affected

- Ongentys

Details

Criteria	Step 1: Generic entacapone. Step 2: Ongentys

DPP4 THERAPY - UAW TRUST

Products Affected

- Nesina

Details

Criteria	Step 1: Both of the following: Januvia and Tradjenta. Step 2: Nesina

FEBUXOSTAT - UAW TRUST

Products Affected

- Febuxostat

Details

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

FILGRASTIM NON - PREFERRED THERAPY - UAW TRUST

Products Affected

- Granix
- Neupogen
- Nivestym

Details

Criteria	Step 1: Zarxio. Step 2: Neupogen, Granix, Nivestym

GLP1 AGONIST AND INSULIN COMBO

Products Affected

- Xultophy 100/3.6

Details

Criteria	Step 1: Soliqua. Step 2: Xultophy

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

PANCREATIC ENZYME THERAPY - UAW TRUST

Products Affected

- Pancreaze CPEP 149900UNIT; 37000UNIT; 97300UNIT, 15200UNIT; 2600UNIT; 8800UNIT, 24600UNIT; 4200UNIT; 14200UNIT, 61500UNIT; 10500UNIT; 35500UNIT, 83900UNIT; 21000UNIT; 54700UNIT, 98400UNIT; 16800UNIT; 56800UNIT
- Viokace

Details

Criteria	Step 1: Creon AND Zenpep. Step 2: Viokace, Pancreaze

PEGFILGRASTIM NON - PREFERRED THERAPY - UAW TRUST

Products Affected

- Fulphila
- Ziextenzo

Details

Criteria	Step 1: Neulasta and Udencya. Step 2: Fulphila, Ziextenzo

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, valsartan, 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.

SNRI THERAPY

Products Affected

- Fetzima
- Fetzima Titration Pack

Details

Criteria	Step 1: Generic venlafaxine extended release capsules. Step 2: Fetzima. Approve for continuation of prior therapy.

TOPICAL IMMUNOMODULATOR THERAPY

Products Affected

- Pimecrolimus
- Tacrolimus OINT

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%. Step 2: Generic pimecrolimus, generic tacrolimus topical

TRIPTANS - UAW TRUST

Products Affected

- Almotriptan
- Almotriptan Malate
- Eletriptan Hydrobromide
- Frovatriptan Succinate
- Zolmitriptan TABS
- Zolmitriptan Odt

Details

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

TUDORZA THERAPY

Products Affected

- Tudorza Pressair

Details

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

ZONISADE SUSPENSION THERAPY

Products Affected

- Zonisade

Details

Criteria	Step 1: Generic zonisamide capsule. Step 2: Zonisade suspension. Approve for continuation of prior therapy.