Blue Cross Blue Shield of Michigan
Blue Care Network
Prior authorization and step therapy coverage criteria
July 2025

Blue Cross Blue Shield of Michigan and Blue Care Network work to make sure you get the safest, most effective and most reasonably priced prescription drugs. Our pharmacists do this in many different ways. Prior authorization and step therapy are two of our tools.

What is prior authorization?

Blue Cross and BCN require a review of certain medications before your plan will cover them, which is called prior authorization. This ensures you've tried the preferred alternatives — drugs with a proven track record that may be better tolerated, less expensive or less likely to cause interactions — and the drug is being prescribed appropriately. If your doctor doesn't get prior authorization when required, your drug may not be covered. You should consult with your doctor about an alternative therapy in those cases. Most approved prior authorizations last for a set period of time, usually one year. Once they expire, your doctor must request prior authorization again for future coverage.

What is step therapy?

Step therapy requires that you try one or more preferred drugs before coverage for a more expensive alternative is approved. This ensures all clinically sound and cost-effective treatment options are tried before more expensive medications. If your prescribed treatment doesn't meet the step therapy criteria, it may not be covered. You should consult with your doctor about an alternative therapy.

What kinds of drugs need prior authorization or step therapy?

Blue Cross and BCN may require prior authorization or step therapy for drugs that:

- Have dangerous side effects or can be harmful when combined with other drugs
- Should only be used for certain health conditions
- Can be misused or abused
- Are prescribed when there are preferred drugs available that are just as effective

The criteria for medications that need prior authorization or step therapy are based on current medical information and the recommendations of Blue Cross and BCN's Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts.

Coverage of drugs depends on your prescription drug plan. Not all drugs included in these prior authorization and step therapy guidelines are necessarily covered by your plan. Also, some medications excluded from your prescription drug plan may be covered under your medical plan. Examples include medications that are generally administered in a physician's office or other sites of care, rather than at home by the patient. For drugs covered under commercial Blue Cross or BCN medical benefits, please see the **Blue Cross and BCN Utilization Management Medical Drug List.** Requests for medications not covered by your prescription drug plan are reviewed by Blue Cross and BCN to determine if they are medically necessary for you or if there are other equally effective treatments already covered by your drug plan. In rare cases, Blue Cross and BCN may approve medications that aren't covered by your drug plan.

Prior authorization and pharmacy programs listed in this guideline:

- **BCN Custom Drug List**
- **BCBSM Custom Drug List**
- **BCBSM Clinical Drug List**
- **BCN Custom Select Drug List**
- **BCBSM Custom Select Drug List**
- **Lite Prior Authorization Program**
- **Preferred Therapy Program** — This program encourages using more cost-effective drugs rather than higher-priced, brand-name drugs if a prescription for the brand-name drug hasn't been filled in the last 180 days.
- **Off-Label and High-Cost Specialty program —** Off-label means a drug is being used in a way that hasn't been approved by the U.S. Food and Drug Administration. Drugs with potential for off-label use and high-cost specialty drugs on this list require prior authorization for Blue Cross to cover them.

Questions?
Please call the Customer Service number on the back of your Blue Cross or BCN member ID card if you have questions about:

- Your drug plan's coverage or how these pharmacy programs apply
- A drug claim

Electronic prior authorization for doctors and other health care providers

Your doctor can click here to request an electronic review of your covered drugs that require prior authorization or step therapy.

For oncology and supportive care drugs covered under the pharmacy benefit, prior authorization is required through the Oncology Value Management program, which is administered by OncoHealth. Your doctor can submit prior authorization requests to OncoHealth through Availity. Coverage requires the drug is used in accordance with the FDA-approved prescribing information. In cases where an FDA drug is being used "off label," the use must be consistent with National Comprehensive Cancer Network (NCCN) or other consensus guidelines. Approvals will be granted for at least 60 days and up to six months at a time.

OncoHealth is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing cancer support services.

New coverage criteria for certain drugs

Drug name	Current Blue Cross and BCN coverage criteria	New Blue Cross and BCN coverage criteria	Publish date for the new coverage criteria	Effective date for the new coverage criteria
Nourianz	(For full coverage criteria, please see drug entry below) 1. Treatment of intermittent OFF episodes in patients with Parkinson's Disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Using in combination with carbidopa/levodopa	Current criteria as listed in drug entry below and: 1. Treatment of intermittent "off" episodes in patients with Parkinson's Disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Trial and failure or intolerance to at least one of the following when used in addition to levodopa-based therapy: a. Dopamine agonist b. Catechol-o-methyltransferase (COMT) inhibitor c. Monoaminoxidase-B (MAO-B) inhibitor d. Amantadine	7/1/2025	9/1/2025
Filspari	(For full coverage criteria, please see drug entry below) 1. To slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone, or prednisone	Current criteria as listed in drug entry below and: 1. To slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, OR intolerance to a sodium-glucose cotransporter-2 inhibitor (SGLT2i) 5. Will not be used in combination with a renin-angiotensin system (RAS) inhibitor such as ACEi or ARB or an endothelin receptor antagonist such as Vanrafia	7/1/2025	9/1/2025
Tarpeyo	(For full coverage criteria, please see drug entry below) 1. Intended to reduce the loss of kidney function for the diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone, or prednisone	Current criteria as listed in drug entry below and: 1. To reduce the loss of kidney function for the diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone or prednisone 5. Trial and failure, contraindication, or intolerance to a sodium-glucose cotransporter-2 inhibitor (SGLT2i) 6. Will be used in combination with ACEi or ARB therapy unless contraindicated	7/1/2025	9/1/2025

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Drug name	Current Blue Cross and BCN coverage criteria	New Blue Cross and BCN coverage criteria	Publish date for the new coverage criteria	Effective date for the new coverage criteria
Fabhalta	(For full coverage criteria, please see drug entry below) 1. For reduction of proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) 2. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 3. Trial and failure, contraindication, OR intolerance to generic methylprednisolone, prednisolone or prednisone	Current criteria as listed in drug entry below and: 1. For the reduction of proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, OR intolerance to a sodium-glucose cotransporter-2 inhibitor (SGLT2i) 5. Trial and failure, contraindication, OR intolerance to Tarpeyo 6. Trial and failure, contraindication, OR intolerance to a preferred endothelin receptor antagonist 7. Will be used in combination with ACEi or ARB therapy unless contraindicated 8. Not to be used in combination with Vanrafia, Filspari, or Tarpeyo	7/1/2025	9/1/2025
Alhemo	(For full coverage criteria, please see drug entry below) i. Hemophilia A For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia A with VIII inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor VIII inhibitors measuring greater than 5 BU/mL 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcomes-based results (ie: hemophilia treatment centers) 7. Trial and failure, intolerance, or contraindication to Hemlibra ii. Hemophilia B 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia B with factor IX inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor IX inhibitors measuring greater than 5 BU/mL 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome-based results (ie: hemophilia treatment centers)	Current criteria as listed in drug entry below and: i. Hemophilia A 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia A with VIII inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor VIII inhibitors measuring greater than 5 BU/mL. For those with inhibitors less than 5 BU/mL, a trial and failure of additional higher doses of factor is required. 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcomes-based results (ie: hemophilia treatment centers) 7. Trial and failure, intolerance, or contraindication to Hemlibra ii. Hemophilia B 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia B with factor IX inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor IX inhibitors measuring greater than 5 BU/mL. For those with inhibitors less than 5 BU/mL, a trial and failure of additional higher doses of factor is required. 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome-based results (ie: hemophilia treatment centers)	7/1/2025	9/1/2025

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Galzin		Coverage is provided for the maintenance treatment of patients with Wilson's disease who have been initially treated with a chelating agent Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	7/1/2025	9/1/2025

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Accrufer	Coverage requires the following: 1. Diagnosis of iron deficiency 2. Age ≥ 18 years old 3. Trial and failure or intolerance to two over-the-counter iron products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Acthar Gel	Coverage is provided for the treatment of infantile spasms (West Syndrome) for children less than 2 years old Approval: 60 days	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
adapalene/benzoyl peroxide (Epiduo Forte)	Coverage requires the following: 1. Diagnosis of acne 2. Trial and failure, contraindication, or intolerance to three generic or preferred topical agents for the treatment of acne, one of which must be benzoyl peroxide and another must be adapalene Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Adbry	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis (AD) 2. Age ≥ 12 years old** 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil **Adbry autoinjector is intended for use only in adults Adbry will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Addyi	Coverage requires the following: 1. Premenopausal female ≥ 18 years old 2. Diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that has been ongoing for more than 6 months 3. Other causes (such as relationship difficulty, substance abuse, medication side effects) of HSDD must be ruled out Initial approval: 60 days Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Adempas	Coverage requires the following: 1. Diagnosis of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH OR 1. Diagnosis of Pulmonary Arterial Hypertension (PAH)(WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓
Adlarity	Coverage requires the following: 1. Diagnosis of mild, moderate, and severe dementia of Alzheimer's type 2. Trial and failure or intolerance to generic oral donepezil Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Adzenys ER, amphetamine suspension	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (methylphenidate ER, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Adzenys XR-ODT	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (methylphenidate ER, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Afrezza	Coverage is provided when the member has experienced treatment failure or intolerance to Novolog	✓	✓	**NC**	✓			✓	**NC**
Agamree	Coverage requires the following: 1. Diagnosis of Duchenne Muscular Dystrophy (DMD) 2. Age ≥ 2 years old 3. Trial and failure, contraindication, or intolerance to adequate doses (0.75 mg/kg/day) of generic prednisone or generic prednisolone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Aimovig	Coverage requires the following: 1. Age ≥ 18 years old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Not to be used in combination with other CGRP antagonists for migraine prevention Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ajovy	Coverage requires the following: 1. Age ≥ 18 years old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Trial and treatment failure of Aimovig and Emgality 6. Not to be used in combination with other CGRP antagonists for migraine prevention Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Akynzeo	Coverage is provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril) 2. Preferred NK1 antagonist (ex. Emend). 3. Glucocorticoid (dexamethasone)	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Alhemo	Coverage requires the following: i. Hemophilia A 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia A with VIII inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor VIII inhibitors measuring greater than 5 BU/mL 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcomes-based results (ie: hemophilia treatment centers) 7. Trial and failure, intolerance, or contraindication to Hemlibra ii. Hemophilia B 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia B with factor IX inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of a historical or current high titer for factor IX inhibitors measuring greater than 5 BU/mL 5. Will not be used in combination with Immune Tolerance Induction (ITI) 6. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome-based results (ie: hemophilia treatment centers) Initial approval: 6 months Continuation of coverage will be provided when treatment has been proven successful through a decrease in the number of bleeds	✓	✓	✓	✓	✓	✓	✓	✓

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Alkindi Sprinkle	Coverage requires the following: 1. Diagnosis of adrenocortical insufficiency 2. Age ≤ 6 years old OR 2. Member cannot swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
almotriptan (Axert)	Coverage requires trial of 2 of the following generic triptans: Imitrex, Maxalt, Amerge or Zomig/ZMT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Alyftrek	Coverage requires the following: 1. Diagnosis of cystic fibrosis (CF) 2. Age ≥ 6 years old 3. Presence of at least one F508del mutation or another responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene 4. Member is not using Alyftrek in combination with another CFTR potentiator such as: Trikafta, Orkambi, Kalydeco, or Symdeko Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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ambrisentan (Letairis)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓		✓	✓
anastrozole (Arimidex)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer 3. Members is classified as high risk 4. Does not have a history of breast cancer 5. Member is currently post-menopausal	✓	✓	✓	✓	✓		✓	✓
Aptiom	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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Aqneursa	Coverage requires the following: 1. Treatment of neurologic manifestations of Niemann-Pick type C (NPC) 2. Diagnosis is confirmed via one of the following: a. Genetic confirmation of biallelic pathogenic or likely pathogenic mutations in the NPC1 or NPC2 genes b. One pathogenic or likely pathogenic mutation in the NPC1 or NPC2 genes and either a positive filipin staining test or elevated cholestane triol/oxysterols c. Two variants of uncertainty in the NPC1 or NPC2 genes and either a positive filipin staining test or elevated cholestane triol/oxysterols 3. Age ≥ 18 years old or weight ≥ 15kg 4. Must present with neurological manifestations of Niemann-Pick type C (NPC), such as, hypotonia, developmental delays, speech delay, dysphagia, ataxia, abnormal eye movements, and/or cataplexy 5. Not to be used in combination with other medications for the treatment of NPC disease with the exception of generic miglustat Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Arcalyst	Coverage requires the following: 1. Treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) 2. Age ≥ 12 years old 3. Laboratory evidence of a genetic mutation OR elevated inflammatory markers plus at least two of six typical CAPS manifestations: (urticaria-like rash, cold-triggered episodes, hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, or skeletal abnormalities) OR 1. Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) 2. Laboratory evidence of homozygous genetic mutations of IL1RN 3. Weight ≥ 10 kg 4. Trial and failure, contraindication, or intolerance to Kineret OR 1. Diagnosis of recurrent pericarditis (RP) 2. Age ≥ 12 years old 3. Trial and treatment failure or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs) in combination with colchicine 4. Trial and treatment failure or intolerance to Kineret Arcalyst will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Arikayce	Coverage requires the following: 1. Diagnosis of mycobacterium avium complex (MAC) 2. Age ≥ 18 years old Initial approval: 1 year	✓	✓	✓	✓	✓	✓	✓	✓
Auvelity	Coverage requires trial and failure of at least three antidepressant agents Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Austedo	Coverage requires the following: 1. Diagnosis of chorea associated with Huntington's disease 2. Trial and failure or intolerance to Xenazine OR 1. Diagnosis of Tardive Dyskinesia Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Austedo XR	Coverage requires the following: 1. Diagnosis of chorea associated with Huntington's disease (HD) 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to generic Xenazine (tetrabenazine) OR 1. Diagnosis of tardive dyskinesia 2. Age≥ 18 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Azstarys	Coverage requires the following: 1. Diagnosis of attention deficit hyperactivity disorder (ADHD) 2. Age ≥ 6 years old 3. Trial and treatment failure or intolerance to one generic stimulant, such as a generic amphetamine product or a generic methylphenidate product Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
baclofen suspension (Fleqsuvy)	Coverage requires the following: 1. Diagnosis of spasticity 2. Trial and failure or intolerance to baclofen tablets OR member is unable to swallow tablets 3. Trial and failure or intolerance to Lyvispah Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Beconase AQ	Coverage requires trial and failure/intolerance of 2 of the following intranasal steroids: generic fluticasone (Flonase), generic flunisolide (Nasalide), or generic triamcinolone (Nasacort AQ) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Belsomra	Coverage requires treatment failure of ONE of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Benlysta	Coverage requires the following: 1. Age ≥ 5 years old 2. Diagnosis of systemic lupus erythematosus (SLE) 3. Patients have tested positive for serum antibodies at 2 independent time points 4. If patient has lupus nephritis ONLY and no other symptoms of SLE, patient must have active disease of the kidney confirmed on biopsy 5. Does not have severe active CNS lupus 6. Previous treatment courses of at least 12 weeks each with 2 or more of the following have been ineffective: hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide or mycophenolate, unless all are contraindicated or not tolerated 7. Patient is currently receiving, and will continue to receive standard of care regimen (examples include antimalarials, corticosteroids, and non-biologic immunosuppressants) 8. Not to be used in combination with other biologics, B-cell targeted therapies Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Bimzelx	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of three of the following: Enbrel, preferred adalimumab biosimilar, Otezla, Skyrizi, preferred ustekinumab biosimilar and Tremfya 5. Trial and treatment failure of Taltz OR 1. Diagnosis of Psoriatic Arthritis	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	2. Age ≥ 18 years old 3. Trial and treatment failure of three of the following: Enbrel, preferred adalimumab biosimilar, Otezla, Simponi, preferred ustekinumab biosimilar, Skyrizi, Tremfya, Rinvoq, Xeljanz/XR 4. Trial and treatment failure of Taltz OR 1. Diagnosis of Non-Radiographic Axial Spondyloarthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one tumor necrosis factor (TNF) inhibitor, Rinvoq, and Taltz OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of three of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq, Simponi, Xeljanz/XR 4. Trial and treatment failure of Taltz OR 1. Diagnosis of Hidradenitis Suppurativa 2. Age ≥ 18 years old 3. Previous 3-month trial of oral antibiotics 4. Trial and treatment failure of preferred adalimumab biosimilar Bimzelx will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic agents (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bonjesta	Coverage requires the following: 1. Treatment of nausea and vomiting of pregnancy 2. Age ≥ 18 years old 3. Trial and treatment failure of the individual agents (doxylamine and pyridoxine) in combination 4. Trial and failure of or intolerance to generic Diclegis (doxylamine/pyridoxine) Approval length: 9 months	✓	✓	**NC**	✓	✓	✓	✓	**NC**
bosentan (Tracleer)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓
Brexafemme	Coverage requires the following: 1. Treatment of acute vulvovaginal candidiasis (VVC) or recurrent vulvovaginal candidiasis (RVVC) 2. Trial and failure, contraindication, or intolerance to generic oral fluconazole alone Approval: 6 months	✓	✓	✓	✓			✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bronchitol	Coverage requires the following: 1. Using as add-on maintenance therapy to improve pulmonary function in patients with cystic fibrosis (CF) 2. Age ≥ 18 years old 3. Must have passed the Bronchitol Tolerance Test 4. Member will be taking a short-acting bronchodilator 5-15 minutes before every dose of Bronchitol 5. Trial and failure, contraindication, or intolerance to nebulized hypertonic saline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Briviact oral solution + tablet	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Brukinsa	Coverage requires the following: 1. Diagnosis of mantle cell lymphoma (MCL) 2. Treatment failure or intolerance to Calquence OR 1. Diagnosis of Waldenström's macroglobulinemia (WM) 2. Trial and failure or intolerance to Imbruvica OR 1. Diagnosis of marginal zone lymphoma (MZL) 2. Treatment failure or intolerance to one or more rounds of therapy with a CD20 inhibiting antibody OR 1. Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) 2. Treatment failure or intolerance to Calquence or Imbruvica OR 1. Diagnosis of relapsed or refractory follicular lymphoma (FL) 2. Using in combination with obinutuzumab 3. Treatment failure of two or more lines of systemic therapy	✓	✓	✓	✓	✓	✓	✓	✓
buprenorphine hcl (Belbuca)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to two long-acting opioids, one of which must be buprenorphine transdermal patch Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bylvay	Coverage requires the following: 1. For the treatment of pruritus in patients with a diagnosis of progressive familial intrahepatic cholestasis (PFIC) 2. Age ≥ 3 months old 3. Genetic testing does not show presence of the ABCB11 variants resulting in a nonfunctional or complete absence of the bile salt export pump protein (BSEP-3). 4. No history of liver transplant or planned future liver transplant 5. No clinical evidence of decompensated cirrhosis 6. Trial and failure, contraindication, or intolerance to generic ursodiol OR 1. For the treatment of cholestatic pruritus in patients with a diagnosis of Alagille syndrome (ALGS) 2. Diagnosis is confirmed by documentation of 1 of the following: a. Genetic testing shows presence of the JAG1 or NOTCH2 genetic mutation b. Liver biopsy shows bile duct scarcity c. Involvement of 3 of 7 of the main organ systems affected in ALGS: hepatic, ocular, skeletal, vascular, facial, cardiac, or renal involvement 3. Age ≥ 12 months old 4. No history of liver transplant or planned future liver transplant 5. No clinical evidence of decompensated cirrhosis 6. Trial and failure, contraindication, or intolerance to generic ursodiol 7. Trial and failure, contraindication, or intolerance to Livmarli Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cablivi	Coverage requires the following: 1. Diagnosis of acquired aTTP 2. Administered in addition to plasma exchange and immunosuppressive therapy 3. Continued 30 days after discontinuation of plasma exchange Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓
Camzyos	Coverage requires the following: 1. Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM) 2. New York Heart Association (NYHA) class II-III 3. Age ≥ 18 years old 4. Left ventricular ejection fraction (LVEF) > 55% 5. Trial and failure, contraindication, or intolerance to a beta blocker or calcium channel blocker Initial approval: 1 year Renewal requires that the medication is providing clinical benefit and that LVEF is ≥ 50%	✓	✓	✓	✓	✓	✓	✓	✓
Caplyta	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
carglumic acid (Carbaglu)	Coverage requires the following: 1. Adjunctive and maintenance therapy for the treatment of hyperammonemia due to NAGSD, a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) 2. Deficiency must be confirmed by enzyme or DNA mutation analysis Initial approval for NAGSD: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit OR 1. Adjunctive treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) 2. Diagnosis must be confirmed by analysis of organic acids in urine and assessment of the acylcarnitine profile in blood Approval for PA or MMA: 60 days	✓	✓	✓	✓	✓	✓	✓	✓
Caverject	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Cayston	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in members with cystic fibrosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cerdelga	Coverage requires the following: 1. Age ≥ 18 years old 2. For the long-term treatment of Gaucher disease type 1 (GD1) 3. Confirmation of diagnosis by biochemical assay showing decreased glucocerebrosidase activity in white blood cells or skin fibroblasts AND genotyping revealing two pathogenic mutations of the glucocerebrosidase gene 4. Two symptomatic manifestations of the disease are present, such as anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly 5. CYP2D6 genotyping by an FDA-cleared test reveals an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
cetrorelix (Cetrotide)	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Chenodal	Coverage requires the following: 1. Treatment of gallstones 2. Ineligible for surgery 3. Treatment failure or intolerance to Actigall (ursodiol) OR 1. Treatment of cerebrotendinous xanthomatosis (CTX) 2. CTX diagnosis must be confirmed by BOTH of the following: i. Genetic testing showing a mutation in the CYP27A1 gene ii. Elevated serum cholestanol level 3. Age ≥ 18 years old Coverage for the treatment of gallstones is limited to 24 months Initial approval for the treatment CTX: 1 year Renewal for the treatment of CTX requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Cholbam	Coverage requires the following: 1. Prescribed by or in consultation with hepatologist or gastroenterologist 2. Treatment of bile acid synthesis disorder due to single enzyme defects (SEDs) OR 1. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestation of liver disease, steatorrhea or complications from decreased fat-soluble vitamin deficiency 2. Prescribed by or in consultation with a hepatologist or gastroenterologist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
chorionic gonadotropin (HCG) (Novarel)	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice. 2. The members benefit provides for coverage for infertility medications 3. Coverage may be provided in accordance with your medical fertility benefit 4. Trial and treatment failure of Pregnyl OR For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males OR 1. Prepubertal cryptorchidism not caused by anatomic obstruction	✓	✓	**NC**	✓	✓		✓	**NC**
Cibinqo	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis (AD) 2. Age ≥ 12 years old 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil Cibinqo will not be used in combination with other biologics, targeted disease-modifying antirheumatic drugs (DMARDs), or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Cimzia	Coverage requires the following: 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure of four of the following: preferred adalimumab biosimilar, Rinvoq, Skyrizi, Tremfya, and preferred ustekinumab biosimilar OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, Rinvoq, Xeljanz/XR 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of three of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq, Simponi, Xeljanz/XR 4. Trial and treatment failure of Taltz OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, preferred ustekinumab biosimilar, Skyrizi, Tremfya, Rinvoq/LQ, Xeljanz/XR 4. Trial and treatment failure of Taltz and Orencia OR 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of three of the following: Enbrel, preferred adalimumab biosimilar, Otezla, Skyrizi, preferred ustekinumab biosimilar, Tremfya 5. Trial and treatment failure of Taltz OR 1. Diagnosis of active Non-Radiographic Axial Spondyloarthritis with objective signs of inflammation 2. Age ≥ 18 years old OR 1. Diagnosis of polyarticular Juvenile Idiopathic Arthritis (pJIA) 2. Age ≥ 2 years old 3. Trial and failure of at least 3 months of one DMARD unless contraindicated or not tolerated. Examples include methotrexate and leflunomide 4. Trial and treatment failure of two of the following: preferred adalimumab biosimilar, Enbrel, Rinvoq/LQ, Xeljanz/oral solution 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia Cimzia will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Compounds	Coverage requires the following: 1. The compound is medically necessary for the member's condition 2. The compound contains only FDA-approved drugs 3. There are no appropriate FDA-approved commercial formulations of the compound available 4. There is medical literature to support the safety, effectiveness and route of administration of the compound	✓	✓	✓	✓	✓		✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Continuous Glucose Monitors Dexcom G6 Dexcom G7 Freestyle Libre 14 day Freestyle Libre 2 14 day Freestyle Libre 3 Freestyle Libre 3 Plus	Coverage requires the following: 1. Member is insulin-requiring OR 1. Member has a diagnosis of diabetes and history of problematic hypoglycemia with at least one of the following: a. Recurrent (more than one) level 2 hypoglycemia events (glucose < 54 mg/dL (3.0mmol/L) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan b. A history of one level 3 hypoglycemia event (glucose < 54 mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia OR 1. Member has a diagnosis of diabetes and is currently pregnant and experiencing post prandial hyperglycemia OR 1. Physician attests to active participation in the Michigan Collaborative for Type 2 Diabetes (MCT2D) Collaborative Quality Initiative (CQI) AND attests that the member has a diagnosis of diabetes (Type 1 or Type 2) OR 1. Physician attests to active participation in the Provider Delivered Care Management (PDCM) program AND attests that the member has a diagnosis of diabetes (Type 1 or Type 2) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Contraceptives	Coverage for $0 copayment will be provided when: 1. Used for the prevention of pregnancy 2. Trial and treatment failure or intolerance to at least three generic contraceptive medications	✓	✓	✓	✓	✓		✓	✓
Contrave	Coverage requires the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products Initial approval: 6 months Continued coverage will be reviewed annually and may be provided if the member has maintained a 5% weight loss from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI ≥ 18.5 kg/m2 must be submitted to the plan for review	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Crenessity	Coverage requires the following: 1. Diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency confirmed by one or more of the following: i. Positive newborn screening with confirmatory second-tier testing ii. Elevated early morning (i.e., before 8am) 17-hydroxyprogesterone (17-OHP) level evaluated by liquid chromatography-tandem mass spectrometry (LC-MS/MS) iii. Cosyntropin stimulation testing iv. Confirmed CYP21A2 genotype 2. Age ≥ 4 years old 3. Established on supraphysiologic doses of glucocorticoids as follows: i. Adults: > 13 mg/m2 per day in hydrocortisone dose equivalents ii. Pediatrics: > 12 mg/m2 per day in hydrocortisone dose equivalents 4. Must be used in combination with glucocorticoid therapy 5. For solution requests only: Physician must provide documentation that the member cannot swallow whole tablets or capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Crexont	Coverage requires trial and treatment failure of generic Sinemet CR Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Crinone 8%	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART) 4. Trial and treatment failure of Endometrin	✓	✓	**NC**				✓	**NC**
Cystadrops	Coverage is provided for the treatment of corneal cystine crystal accumulation in patients with cystinosis, when taking in combination with oral Cystagon.	✓	✓	✓	✓	✓	✓	✓	✓
Cystaran	Coverage is provided for the treatment of corneal cystine crystal accumulation in patients with cystinosis, when taking in combination with oral Cystagon	✓	✓	✓	✓	✓	✓	✓	✓
Daybue	Coverage requires the following: 1. Diagnosis of classic Rett syndrome consistent with the RettSearch Consortium diagnostic criteria 2. Does not have atypical or variant Rett syndrome 3. Age ≥ 2 years old Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dayvigo	Coverage requires treatment failure of ONE of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
deferiprone tablets (Ferriprox)	Coverage requires the following: 1. Age ≥ 8 years old 2. Diagnosis of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate 3. Treatment failure or intolerance to generic Jadenu or generic Exjade Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
deferiprone solution (Ferriprox)	Coverage requires the following: 1. Age ≥ 3 years old 2. Diagnosis of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate 3. Treatment failure or intolerance to generic Jadenu or generic Exjade Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
deflazacort (Emflaza)	Coverage requires the following: 1. Diagnosis of Duchenne Muscular Dystrophy (DMD) 2. Age ≥ 2 years old 3. Trial and treatment failure, contraindication, or intolerance to adequate doses (0.75 mg/kg/day) of generic of prednisone or prednisolone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Descovy 200mg-25mg	Coverage with $0 copayment will be provided when: 1. For prevention of HIV infection in members who are at a high risk of getting HIV 2. Member is not taking concomitant antiretroviral therapy Initial approval: 2 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit AND documentation of a negative HIV test result within the past 3 months	✓	✓	✓	✓	✓		✓	✓
Desvenlafaxine ER	Coverage requires trial and failure of at least three antidepressant agents Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dexilant / dexlansoprazole	Coverage requires failure of or intolerance to four of the following generic alternatives: omeprazole (Prilosec), esomeprazole (Nexium), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		**NC**	**NC**
Diacomit	Coverage requires the following: 1. Diagnosis of Dravet Syndrome 2. Trial and failure, contraindication, or intolerance to 2 of the following generic options: valproic acid, clobazam, or topiramate 3. Using in combination with clobazam Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
dichlorphenamide (Keveyis)	Coverage requires the following: 1. Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis and related variants 2. Diagnosis is confirmed via genetic testing showing a mutation on the SCN4A or CACNA1S genes OR a positive family history 3. Trial and failure of lifestyle modifications such as diet (potassium intake alterations) and exercise modifications (e.g. avoidance of strenuous exercise) 4. Trial and failure, contraindication, or intolerance to acetazolamide Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
diclofenac 2% external solution (Pennsaid 2%)	Coverage requires the following: 1. Diagnosis of osteoarthritis of the knee 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs 3. Trial of generic Pennsaid 1.5% topical solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Please note: Coverage will not be provided in the presence of concurrent therapy with oral NSAIDs	✓	✓	**NC**	✓	✓		✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
diclofenac potassium (Zipsor)	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of acute pain 3. Trial and failure of oral diclofenac 4. Trial and failure of two other preferred oral NSAIDs Initial approval: 3 months	✓	✓	**NC**	✓	✓		✓	**NC**
diclofenac sodium 3% gel (Solaraze)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis 3. Trial and failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% Initial approval: 3 months Renewal requires recurrence and/or new lesions	✓	✓	✓	✓	✓		✓	✓
Dojolvi	Coverage requires the following: 1. Treatment of molecularly confirmed long-chain fatty acid oxidation disorders 2. Following low fat/high carbohydrate diet and avoiding fasting 3. Trial of medium chain triglycerides at a maximally tolerated dose Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Doptelet	Coverage requires the following: 1. Diagnosis of thrombocytopenia in chronic liver disease a. Age ≥ 18 years old b. Platelet count < 50,000/mcL c. Scheduled to undergo a procedure OR 2. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 100,000/mcL) for ≥ 3 months and requires all of the following: a. Age ≥ 18 years old b. Current platelet count is < 20,000/mcL or < 30,000/mcL and has symptoms of active bleeding c. Diagnosis confirmed by, or in consultation with a hematologist d. Inadequate response to (e.g. unable to maintain platelet count ≥ 30,000/mcL) OR are not candidates for therapy with corticosteroids, immunoglobulins, or splenectomy with an insufficient response to previous treatment Initial approval for diagnosis of thrombocytopenia in chronic liver disease: 60 days Initial approval for diagnosis of chronic ITP: 3 months Renewal requires a recent platelet count between 50,000 and 200,000/mcL	✓	✓	✓	✓	✓	✓	✓	✓
Doryx MPC	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) AND generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Doxepin topical cream	Coverage requires the following: 1. Diagnosis of atopic pruritis or lichen simplex chronicus 2. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 3. Trial and treatment failure to one preferred topical calcineurin inhibitor (tacrolimus, pimecrolimus) OR 1. Diagnosis of peripheral neuropathic pain 2. Trial and treatment failure of two over-the-counter topical analgesics 3. Trial and treatment failure of one preferred topical non-steroidal anti-inflammatory drug (NSAID) Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓
doxycycline hyclate (Doryx)	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) AND generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
doxycycline monohydrate (Adoxa / Adoxa Pak)	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) AND generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Duopa	Coverage requires the following: 1. For the treatment of motor fluctuations in advanced Parkinson's disease (PD) 2. Age ≥ 18 years old 3. Member must be established on and responsive to a levodopa-containing treatment regimen 4. Current treatment regimen must include at least one of the following in addition to levodopa-based therapy: a. Dopamine agonist b. Catechol-o-methyltransferase (COMT) inhibitor c. Monoaminoxidase-B (MAO-B) inhibitor d. Amantadine 5. Motor fluctuations are inadequately controlled by current treatment regimen, with member experiencing an average of at least 2.5 hours of "off" time per day Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dupixent	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis 2. Age ≥ 6 months old 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacroliumus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil OR 1. Diagnosis of eosinophilic asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Eosinophil count ≥ 150 cells/microliter at initiation of treatment 5. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Dupixent (continued)	OR 1. Diagnosis of oral corticosteroid dependent asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids AND high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old OR 1. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) 2. Age > 12 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. CRSwNP is recurring despite previous treatment with intranasal corticosteroids OR 1. Diagnosis of uncontrolled, moderate to severe chronic obstructive pulmonary disease (COPD) 2. Age ≥ 18 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen including LABA + LAMA + ICS, unless not tolerated 4. Evidence of type 2 inflammation (eosinophils ≥ 300/µL) OR 1. Diagnosis of eosinophilic esophagitis (EoE) 2. Age ≥ 1 year old 3. Weight ≥ 15 killograms 4. Trial and treatment failure of a proton pump inhibitor (PPI) OR 4. Trial and treatment failure of a swallowed topical glucocorticoid OR 1. Diagnosis of Prurigo Nodularis (PN) 2. Age ≥ 18 years old 3. Trial and treatment failure with topical steroids or topical calcineurin inhibitors Dupixent will not be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Duvyzat	Coverage requires the following: 1. Age ≥ 6 years old 2. Diagnosis of Duchenne muscular dystrophy (DMD), confirmed by genetic testing demonstrating a mutation of the DMD gene 3. Must be on a stable dose of systemic corticosteroids prior to starting therapy with Duvyzat 4. Must be ambulatory prior to starting therapy with Duvyzat Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dyanavel XR	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (methylphenidate ER, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Ecoza	Coverage requires the following: 1. Diagnosis of tinea pedis 2. Treatment failure of 2 topical over-the-counter antifungal agents 3. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine) Approval: 60 days	✓	✓	**NC**	✓			✓	**NC**
Edarbi	Coverage requires that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blockers (ARB) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Edarbyclor	Coverage requires that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blockers (ARB) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓
Edex	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Edluar	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor), one of which must be generic Ambien Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Egrifta	Coverage requires the following: 1. Diagnosis of HIV 2. Currently receiving antiretroviral therapy (ART) 3. Medical complication caused by excess abdominal fat 4. Medical complication due to excess abdominal fat is not responsive to conventional therapy Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Elepsia XR	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to three generic or preferred alternatives, one of which must be generic Keppra Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
eltrombopag (Promacta)	Coverage requires the following: 1. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 100,000 mcL) for ≥ 3 months and requires all of the following: a. Age ≥ 1 year of age b. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins or splenectomy c. Current platelet count is < 20,000 mcL or <30,000 mcL and has symptoms of active bleeding d. Dose does not exceed 75mg/day OR 2. Diagnosis of thrombocytopenia with chronic hepatitis C and requires all of the following: a. ≥18 years of age b. Platelets <75,000 mcL c. Dose does not exceed 100mg/day OR 3. Diagnosis of severe aplastic anemia and requires all of the following: a. ≥ 2 years of age b. Current platelets ≤ 30,000/mcL c. Insufficient response to antithymocyte globulin based immunosuppressive therapy OR c. Using in combination with standard immunosuppressive therapy as first line treatment d. Dose does not exceed 150mg/day Initial approval: 3 months Renewal of therapy requires ALL the following to be met: 1. Recent platelet count between 50,000 and 200,000/mcL OR for platelet counts outside this range, dosage has been adjusted accordingly to FDA labeled recommendations 2. Dose does not exceed recommended maximum for indication	✓	✓	✓	✓	✓	✓	✓	✓

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Emgality 100mg/ml	Coverage requires the following: 1. For the treatment of episodic cluster headache 2. Age ≥18 years old Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Emgality 120mg/ml	Coverage requires the following: 1. Age ≥ 18 years old 2. For preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Not to be used in combination with other CGRP antagonists for migraine prevention Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Empaveli	Coverage requires the following: 1. Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) 2. Age ≥ 18 years old 3. Flow cytometric confirmation of PNH type III red cells 4. Had at least 1 transfusion in 12 months preceding Empaveli OR 4. History of major adverse thrombotic vascular events from thromboembolism OR 4. Patient has high disease activity defined as a lactic dehydrogenase (LDH) level ≥ 1.5 times the upper limit of normal with one of the following symptoms: i. Weakness ii. Fatigue iii. Hemoglobinuria iv. Abdominal pain v. Dyspnea vi. Hemoglobin < 10 g/dL vii. A major vascular event viii. Dysphagia ix. Erectile dysfunction 5. Must not be used in combination with Soliris®, Ultomiris®, or other medications used to treat PNH Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Emsam	Coverage requires the following: 1. Treatment of major depressive disorder 2. Age ≥ 18 years old 3. Member has experienced treatment failure or intolerance to at least three different generic antidepressants	✓	✓	✓	✓	✓		✓	✓
emtricitabine 200mg-tenofovir 300mg (Truvada)	Coverage for $0 copayment will be provided when: 1. For prevention of HIV infection in members who are at a high risk of getting HIV 2. Member is not taking concomitant antiretroviral therapy	✓	✓	✓	✓	✓		✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Enbrel	Coverage requires the following: 1. Diagnosis Psoriatic Arthritis 2. Age ≥ 2 years old OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old OR 1. Diagnosis of Psoriasis 2. Age ≥ 4 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of polyarticular Juvenile Idiopathic Arthritis (pJIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) Enbrel will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Endometrin	Coverage requires the following: 1. It is being prescribed in accordance with generally accepted medical practice 2. The members benefit provides coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Enspryng	Coverage requires the following: 1. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive Enspryng will not be approved for use in combination with Soliris or Uplizna Initial approval: 1 year Continuation of treatment requires of a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Enstilar	Coverage requires the following: 1. Diagnosis of psoriasis 2. Trial and treatment failure with a high potency topical steroid in combination with generic Dovonex 3. Trial and treatment failure with generic Taclonex Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Eohilia	Coverage requires the following: 1. Diagnosis of of eosinophilic esophagitis (EoE) 2. Age ≥ 11 years old 3. Trial and failure, contraindication, or intolerance to a proton pump inhibitor (PPI) OR 3. Trial and failure, contraindication, or intolerance to a swallowed topical glucocorticoid such as inhaled budesonide Approval: 12 weeks	✓	✓	✓	✓			✓	✓
Epclusa / Sofosbuvir + Velpatasvir	Coverage requires the following: 1. Age ≥ 3 years old or weight ≥ 17kg 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Epidiolex	Coverage requires the following: 1. Diagnosis of Lennox-Gastaut syndrome 2. Trial and failure, contraindication, OR intolerance to at least 2 generic alternatives for the treatment of seizures OR 1. Diagnosis of Dravet syndrome 2. Trial and failure, contraindication, OR intolerance to 2 of the following generic options: valproic acid, clobazam, or topiramate OR 1. Treatment of seizures associated with tuberous sclerosis complex 2. Trial and failure, contraindication, OR intolerance to 3 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Eprontia	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR member is unable to swallow tablets/capsules OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) OR member is unable to swallow tablets/capsules OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR member is unable to swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Eucrisa	Coverage requires trial and treatment failure of one of the following: a topical steroid, generic Protopic, or generic Elidel Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Eulexin	Coverage requires the following: 1. Diagnosis of locally confined or metastatic carcinoma of the prostate 2. Age ≥ 18 years old 3. Using in combination with luteinizing hormone-releasing hormone (LHRH)-agonists 4. Trial and failure, contraindication, or intolerance to generic Casodex (bicalutamide)	✓	✓	✓	✓	✓	✓	✓	✓
Evrysdi	Coverage requires the following: Diagnosis of type 1, 2, or 3 Spinal Muscular Atrophy (SMA) confirmed by genetic testing AND 1. Prescribed by or in consultation with a neurologist specializing in neuromuscular disorders 2. Submission of a baseline, age appropriate exam to establish baseline motor function and ability 3. Patient is not concurrently taking SMN2-targeting antisense oligonucleotide or SMN2 splicing modifier AND patient has not had gene therapy treatment for SMA (such as Zolgensma) 4. Patient is not requiring invasive ventilation or tracheostomy Initial approval: 6 months Continuation of treatment requires submission of repeat motor ability assessment and documentation of response to therapy defined as a clinically significant improvement in SMA-associated motor milestones and motor function (for example, progression, stabilization, or decreased functional motor decline) compared to predicted natural history and progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
exemestane (Aromasin)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer 3. Members classified as high risk 4. Does not have a history of breast cancer 5. Member is currently post-menopausal 6. Member is not taking any estrogen containing products	✓	✓	✓	✓	✓		✓	✓
Exservan	Coverage requires the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Trial of generic riluzole tablets OR 2. Difficulty swallowing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Fabhalta	Coverage requires the following: 1. Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) 1. Age ≥ 18 years old 2. Flow cytometric confirmation of PNH type III red cells 3. Had at least 1 transfusion in 6 months preceding Fabhalta OR 4. Documented history of major adverse thrombotic vascular events from thromboembolism OR 4. Patient has high disease activity defined as a lactic dehydrogenase (LDH) level ≥ 1.5 times the upper limit of normal with one of the following symptoms: a. Weakness b. Fatigue c. Hemoglobinuria d. Abdominal pain e. Dyspnea f. Hemoglobin < 10 g/dL g. A major vascular event h. Dysphagia i. Erectile dysfunction 5. Must not be used in combination with Soliris, Ultomiris, or other medications to treat PNH 6. Trial and failure, contraindication, or intolerance to Empaveli OR 1. For reduction of proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) 2. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 3. Trial and failure, contraindication, OR intolerance to generic methylprednisolone, prednisolone or prednisone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Fabior	Coverage requires the following: Trial and failure, contraindication, or intolerance to both generic adapalene (Differin) and generic tretinoin (Retin-A, Avita)	✓	✓	**NC**	✓	✓		✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								
Fanapt	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Fasenra pen	Coverage requires the following: 1. Diagnosis of severe uncontrolled eosinophilic asthma 2. Age ≥ 6 years old 3. Patient is currently receiving and will continue to receive standard of care regimen 4. Severe eosinophilic asthma identified by: a. Blood eosinophils greater than or equal to 150 cells/microliter at initiation of treatment AND b. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: i. LABA (long acting inhaled β2 agonist) OR ii. Leukotriene modifier OR iii. LAMA (long acting muscarinic antagonist) in adults and children ≥ 12 years old OR	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	1. Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) 2. Age ≥18 years old 3. Consult with an allergist/immunologist prior to initiation of Fasenra therapy 4. History or presence of asthma 5. Presence of at least 2 of the following criteria that are typical of EGPA: histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation, neuropathy, pulmonary infiltrates, allergic rhinitis and nasal polyps, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura, or antineutrophil cytoplasmic antibody (ANCA) positivity Fasenra will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								
fentanyl citrate buccal lollipop (Actiq)	Coverage requires the following: 1. Medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long acting opioid 4. Treatment failure or intolerance to oral immediate release opioids (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fentora; fentanyl citrate buccal tablet	Coverage requires the following: 1. Medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long acting opioid 4. Treatment failure or intolerance to oral immediate release opioids (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Fetzima	Coverage requires trial and failure of at least three antidepressant agents Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Filspari	Coverage requires the following: 1. To slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone, or prednisone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Filsuvez	Coverage requires the following: 1. For the treatment of wounds associated with dystrophic epidermolysis bullosa (DEB) and junctional epidermolysis bullosa (JEB) 2. Age ≥ 6 months old 3. Open wounds requiring treatment 4. Must not have current evidence or a history of malignancy (e.g., basal cell carcinoma, squamous cell carcinoma), or active infection in the area undergoing treatment 5. Must not have undergone stem cell transplant or gene therapy for the treatment of inhereited epidermolysis bullosa Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Finacea foam	Coverage requires the following: 1. Trial and failure, contraindication, or intolerance to generic topical metronidazole 2. Trial and failure, contraindication, or intolerance to generic oral tetracycline, generic doxycycline or generic minocycline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Fintepla	Coverage requires the following: 1. Treatment of seizures associated with Dravet syndrome 2. Age ≥ 2 years old 3. Trial and treatment failure of two of the following: valproic acid, clobazam, topiramate OR 1. Treatment of seizures associated with Lennox-Gastaut syndrome 2. Age ≥ 2 years old 3. Trial and treatment failure of 2 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Firazyr	Coverage requires the following: 1. Treatment of acute attacks of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. Prescribed by an immunologist, allergist or hematologist 4. Trial and treatment failure of generic Firazyr (icatibant) 5. Not to be used in combination with other products indicated for acute HAE attacks Initial approval: 1 year Renewal requires objective data documenting at least 50% improvement in time to relief of symptoms of acute attacks and maintenance of improvement of symptoms	✓	✓	✓	✓	✓	✓	✓	✓
Firdapse	Coverage requires the following: 1. Treatment of Lambert-Eaton myasthenic syndrome 2. Age ≥ 6 years old 3. Prescribed by a neurologist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Flector, Diclofenac Epolamine 1.3% patch	Coverage requires the following: 1. Diagnosis of acute pain due to minor strains, sprains or contusions 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs Initial approval: 3 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit Please note: Coverage will not be provided in the presence of concurrent therapy with oral NSAIDs	✓	✓	NC	✓	✓	✓	✓	NC
Follistim AQ	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. Requires a previous trial of Gonal-f or Gonal-f RFF 3. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit	✓	✓	✓	✓			✓	✓
frovatriptan (Frova)	Coverage requires trial of 2 of the following generic triptans: Imitrex, Maxalt, Amerge, or Zomig/ZMT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Fulphila	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Furoscix	Coverage requires the following: 1. For the treatment of edema in chronic heart failure or chronic kidney disease, including the nephrotic syndrome. 2. Age ≥ 18 years old 3. Patient is experiencing an increase in signs and symptoms of congestion due to fluid overload 4. Established on background therapy with a loop diuretic 5. Patient is stable and does not require emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓
gabapentin (Gralise)	Coverage requires the following: Diagnosis of post-herpetic neuralgia (PHN) AND 1. < 65 years of age 2. Trial and failure, contraindication, or intolerance to generic Neurontin (gabapentin) 3. Trial and failure, contraindication, or intolerance to generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) OR 1. ≥ 65 years of age 2. Trial and failure, contraindication, or intolerance to generic Neurontin (gabapentin)	✓	✓	**NC**		✓		✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Galafold	Coverage requires the following: 1. Diagnosis of Fabry's disease confirmed by genetic testing showing an amenable mutation in the GLA gene a. In addition for males: serum assay of enzyme α-galactosidase showing decreased activity in plasma and/or leukocytes 2. Age ≥ 18 years old 3. Prescribed by or in consultation with a geneticist or metabolic specialist 4. Initiation of therapy should begin as follows: a. Males with classic disease: at time of diagnosis b. Females and males with atypical disease: once patient is showing symptoms of Fabry's disease Galafold will not be approved for use in combination or with any other molecular chaperone or enzyme replacement therapy for Fabry's disease	✓	✓	✓	✓	✓	✓	✓	✓
ganirelix Acetate (generic only)	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Gattex	Coverage requires the following: 1. Diagnosis of Short Bowel Syndrome (SBS) 2. Dependent on parenteral support ≥ 12 months Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, defined as a reduction in ≥ 20% of weekly parenteral nutrition volume or intravenous fluid volume	✓	✓	✓	✓	✓	✓	✓	✓
Gelnique	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Gemtesa	Coverage requires the following: 1. Trial and treatment failure or intolerance to two preferred therapies for overactive bladder (OAB) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Glassia	Coverage requires the following: 1. Age ≥ 18 years old 2. Must be a nonsmoker 3. Member must have pre-treatment serum levels of alpha-1 antitrypsin (AAT) that are less than 11 micromol/L measured by ELISA (less than 80 mg/dlL measured by radial immunodiffusion or less than 57 mg/dL measured by nephelometry) consistent with phenotypes PiZZ, PiZ (null), or Pi (null, null) of AAT a. Phenotype/genotype testing may be requested for additional support of alpha-1 antitrypsin deficiency diagnosis 4. Member must have symptoms with their emphysema 5. Member must have deteriorating lung function, as demonstrated by a decline in the FEV1 (35-60% of predictive value) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Gonal-f, Gonal-f RFF	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit			✓				✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Grastek	Coverage requires the following: 1. Age 5 through 65 years old 2. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (adults) **Preferred** Genotropin Norditropin **Non-preferred** Humatrope Ngenla Nutropin Nutropin AQ Omnitrope Saizen Sogroya Zomacton	Coverage requires the following: 1. Documentation of at least one known cause for pituitary disease or condition affecting pituitary function (i.e. pituitary tumor, traumatic brain injury, surgical damage, hypothalamic disease, irradiation, trauma, history of childhood growth hormone deficiency, or infiltrative disease), with one of the following (A, B, C, or D): A. Failed at least one clinically validated, clearly documented growth hormone stimulation test i. IGF-1 level below age and BMI-corrected lower limit of reference labs normal range ii. For suspected growth hormone deficiency due to traumatic brain injury, GH stimulation test must be administered at least one-year post brain injury iii. For history of childhood growth hormone deficiency, GH stimulation test to be done after growth hormone has been discontinued for at least one month OR B. Failed at least one clearly documented, clinically validated growth hormone stimulation test i. IGF -1 level below age and BMI-corrected lower limit of reference labs normal range ii. Documentation of two additional pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement OR C. Three pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement i. IGF-1 level below age and BMI-corrected lower limit of reference labs normal range OR D. Failed at least two clearly documented, clinically validated GH stimulation tests i. IGF-1 level below age and BMI-corrected lower limit of reference lab's normal range **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (adults) (continued)	OR 1. Diagnosis of HIV wasting or cachexia 2. Unexplained weight loss > 10% of baseline 3. Concomitant anti-viral therapy for the duration of treatment OR 1. Diagnosis of short bowel syndrome 2. Receiving specialized nutritional support, which may include dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient supplements Approval for short bowel syndrome: 4 weeks of treatment Initial approval for Growth Hormone Deficiency and HIV wasting or cachexia: 1 year Renewal for Growth Hormone Deficiency and HIV wasting or cachexia requires that current criteria are met, and that the medication is providing clinical benefit Coverage for a non-preferred medication requires treatment failure to ALL preferred medications (Genotropin and Norditropin)	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (pediatrics) **Preferred** Genotropin Norditropin **Non-preferred** Humatrope Nutropin Nutropin AQ Omnitrope Saizen Skytrofa Sogroya Zomacton	Coverage requires the following: 1. Diagnosis of Growth Hormone Deficiency with ONE of the following: a. 2 subnormal growth hormone stimulation tests, or b. 1 subnormal growth hormone stimulation test AND IGF-1 and IGFBP3 levels below normal for children of the same age and gender, or c. Documentation of a hypothalamic pituitary defect (such as a major congenital malformation, tumor, surgery, irradiation, or trauma) AND a deficiency in at least one additional pituitary hormone AND 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses OR 1. Diagnosis of Growth Hormone Deficiency due to congenital hypopituitarism in a newborn 2. Documentation of hypoglycemia with associated with growth hormone levels <5 mcg/L AND a. Documentation of deficiency of at least one additional pituitary hormone, or b. Imaging to support a pituitary defect (such as ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk OR 1. Diagnosis of Turners Syndrome, SHOX deficiency, or Noonan Syndrome 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Growth Hormone (pediatrics) (continued)	OR 1. Chronic Renal Insufficiency 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses 5. If post-transplant – persistent growth failure without spontaneous catch up one year post-transplant and in whom steroid-free immunosuppression is not feasible OR 1. Small for Gestational Age (SGA) 2. Birth weight and/or length at least 2 standard deviations below the mean for gestational age 3. Fails to manifest catch-up growth by 2 years of age 4. Open epiphyses Authorization period for Growth Hormone Deficiency, Turner's Syndrome, Chronic Renal Insufficiency, SHOX deficiency, Noonan Syndrome, and SGA: Approved until 18th birthday Renewal requires that the patient has documented growth velocity of at least 2.5 cm/year during the first 6 months of treatment and documented growth of at least 4.5 cm/year for each succeeding 6-month review AND open epiphyses OR 1. Diagnosis of Prader-Willi Syndrome OR 1. Pediatric Burn 2. Burns over at least 40% of total body surface area Initial approval for Prader-Willi Syndrome: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Coverage for a non-preferred medication requires treatment failure to ALL preferred medications (Genotropin and Norditropin)	✓	✓	✓	✓	✓	✓	✓	✓
Haegarda	Coverage requires the following: 1. Diagnosis of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%)	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	3. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 4. Prescribed by an immunologist, allergist or hematologist 5. Not to be used in combination with other products indicated for HAE prophylaxis Initial approval: 1 year Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR that the severity of HAE attacks was reduced by 50% or more								
Harvoni / Ledipasvir +Sofosbuvir	Coverage requires the following: 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1 and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Harvoni oral pellets	Coverage requires the following: 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1 and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Hemlibra	Coverage requires the following: 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia A with inhibitors a. Prescribed and dispensed by a specialist that works in a hemophilia treatment center b. Documentation of a historical or current high titer for factor VIII inhibitors measuring > 5 Bethesda Units per milliliter (BU/mL) c. Will not be used in combination with Immune Tolerance Induction (ITI) d. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) OR 2. For prophylaxis of spontaneous bleeding episodes in patients diagnosed with congenital hemophilia A without inhibitors a. Prescribed and dispensed by a specialist that works in a hemophilia treatment center b. Documentation of severe hemophilia A with factor VIII level <1% OR moderate hemophilia A with factor VIII level between 1%-5% c. Documentation of optimally dosed prophylactic factor VIII product is ineffective for the prevention of spontaneous bleeding events (such as: continuing to have bleeding events or arthroscopic changes within a target joint) d. Documentation of the number of bleeds experienced within the past 12 months e. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) Initial approval: 1 year Continuation of coverage will be provided when treatment has been proven successful through a decrease in the number of bleeds and absence of anti-drug antibodies that impact the clearance or efficacy of Hemlibra	✓	✓	✓	✓	✓		✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Hetlioz LQ	Coverage requires the following: 1. Age 3 to 15 years old 2. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by genetic testing showing deletion of chromosome 17p11.2 OR mutation in the retinoic acid-induced 1 (RAI1) gene a. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND acebutolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Horizant	Coverage requires the following: 1. Diagnosis of Restless Leg Syndrome (RLS) 2. Trial and treatment failure, contraindication, or intolerance to THREE of the following: of generic Mirapex (pramipexole), generic Requip (ropinirole), generic Neurontin (gabapentin), and generic Lyrica (pregabalin) OR 1. Diagnosis of post-herpetic neuralgia (PHN) 2. < 65 years of age 3. Trial and failure, contraindication, or intolerance to generic Neurontin (gabapentin) 4. Trial and failure, contraindication, or intolerance to generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) OR 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≥ 65 years of age 3. Trial and failure, contraindication, or intolerance to generic Neurontin (gabapentin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**		✓		✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
hydrocodone bitartrate (Hysingla ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	**NC**	✓	✓	✓	✓	**NC**
hydrocodone bitartrate (Zohydro ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit. Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
hydromorphone (Exalgo)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently.	✓	✓	**NC**	✓	✓		✓	**NC**
Hyftor	Coverage requires the following: 1. Diagnosis of facial angiofibroma associated with tuberous sclerosis 2. Age ≥ 6 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Hympavzi	Coverage requires the following: 1. For prophylaxis of spontaneous bleeding episodes in patients diagnosed with Hemophilia A without factor VIII inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of severe hemophilia A with factor VIII level <1% OR moderate hemophilia A with factor VIII level between 1%-5%	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	5. Documentation of optimally dosed prophylactic factor VIII product is ineffective for the prevention of spontaneous bleeding events (such as: continuing to have bleeding events or arthroscopic changes within a target joint) 6. Documentation of the number of bleeds experienced within the past 12 months 7. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) 8. Trial and failure, intolerance to Hemlibra OR 1. For prophylaxis of spontaneous bleeding episodes in patients diagnosed with Hemophilia B without factor IX inhibitors 2. Age ≥ 12 years old 3. Prescribed and dispensed by a specialist that works in a hemophilia treatment center 4. Documentation of severe hemophilia B with factor IX level <1% OR moderate hemophilia B with factor IX level between 1%-5% 5. Documentation of optimally dosed prophylactic factor IX product is ineffective for the prevention of spontaneous bleeding events (such as: continuing to have bleeding events or arthroscopic changes within a target joint) 6. Documentation of the number of bleeds experienced within the past 12 months 7. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) Requests for doses greater than 150 mg weekly will require consultation with a Blue Cross Blue Shield medical director to discuss if the patient is a candidate for gene therapy Initial approval: 6 months								

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ibsrela	Coverage requires the following: 1. Trial and treatment failure or intolerance to lactulose or polyethylene glycol 2. Trial and treatment failure or intolerance to Linzess Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
icatibant (Firazyr)	Coverage requires the following: 1. Treatment of acute attacks of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. Prescribed by an immunologist, allergist or hematologist 4. Not to be used in combination with other products indicated for acute HAE attacks Initial approval: 1 year Renewal requires objective data documenting at least 50% improvement in time to relief of symptoms of acute attacks and maintenance of improvement of symptoms	✓	✓	✓	✓	✓	✓	✓	✓

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Imcivree	Coverage requires the following: 1. Age ≥ 2 years old 2. Diagnosis of proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing 3. Genetic testing must demonstrate that the variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance 4. Current weight and BMI (within 30 days) must be submitted to the plan for review 5. Patient has obesity defined as: a. Adult patients: BMI ≥ 30 kg/m^2 b. Pediatric patients: BMI ≥ 95th percentile for children and teens of the same age and sex OR 1. Age ≥ 2 years old 2. Diagnosis of Bardet-Biedl syndrome (BBS) 3. Current weight and BMI (within 30 days) must be submitted to the plan for review 4. Patient has obesity defined as: a. Adult patients: BMI ≥ 30 kg/m^2 b. Pediatric patients: BMI ≥ 95th percentile for children and teens of the same age and sex Initial approval for POMC, PCSK1, or LEPR deficiency: 4 months Initial approval for BBS: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% reduction in baseline body weight OR at least a 5% reduction in baseline BMI for patients with continued growth potential. Current weight (within 30 days) must be submitted to the plan for review.	✓	✓	✓	✓	✓	✓	✓	✓

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imiquimod (Zyclara)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis 3. Trial and failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% OR 1. Age ≥ 12 years old 2. Diagnosis of genital or perianal warts Initial approval: 60 days Renewal requires recurrence and or new lesions	✓	✓	**NC**	✓	✓		✓	**NC**
Immunoglobulins **Non-preferred** Cuvitru	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used. Renewal requires that current criteria are met, and that the medication is providing clinical benefit Coverage requires trial and failure or intolerance to ALL preferred medications (Gammagard and Hizentra)	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Immunoglobulins **Preferred** Gammagard Hizentra **Non-preferred** Cutaquig Gammaked Gamunex-C HyQvia Xembify	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used. Renewal requires that current criteria are met, and that the medication is providing clinical benefit Coverage for a non-preferred medication requires trial and failure or intolerance to ALL preferred medications (Gammagard and Hizentra)	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Increlex	Coverage requires the following: 1. Diagnosis of one of the following: a. Severe primary IGF-1 deficiency b. Growth hormone gene deletion c. Genetic mutation of growth hormone receptor (Laron Syndrome) 2. Current height measurement greater than or equal to 3 standard deviations below normal for age and sex 3. IGF-1 level greater than or equal to 3 standard deviations below normal for age and sex 4. Normal or elevated growth hormone levels based on at least one growth hormone stimulation test 5. Open epiphyses Initial approval: 1 year Continued coverage requires documentation of growth velocity of > 2 cm/year and open epiphyses	✓	✓	✓	✓	✓	✓	✓	✓
Ingrezza	Coverage requires the following: 1. Diagnosis of tardive dyskinesia 2. Age ≥ 18 years old OR 1. Diagnosis of chorea associated with Huntington's disease 2. Age ≥ 18 years old 3. Trial and failure, contraindication or intolerance to generic Xenazine (tetrabenazine) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Inrebic	Coverage requires the following: 1. Treatment of patients with intermediate-2 or high-risk primary or secondary myelofibrosis (MF) 2. Age ≥ 18 years old 3. Trial or treatment failure to Jakafi	✓	✓	✓	✓	✓	✓	✓	✓
Iqirvo	Coverage requires the following: 1. Diagnosis of primary biliary cholangitis (PBC) confirmed by 2 of the 3 following American Association for the Study of Liver Diseases (AASLD) criteria: i. Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) activity ii. Presence of antimitochondrial antibody (AMA) or other PBC-specific autoantibodies if AMA is negative iii. Histologic evidence of PBC seen on biopsy 2. Age ≥ 18 years old 3. Treatment with ursodeoxycholic acid (UDCA) at a dose of 13-15 mg/kg/day is ineffective after at least one year or not tolerated or use is contraindicated 4. Iqirvo is administered with UDCA unless UDCA has been not tolerated or is contraindicated 5. Not to be used in combination with additional second-line therapy for PBC (i.e., Ocaliva® or a second peroxisome proliferator-activated receptor (PPAR) agonist) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Isturisa	Coverage requires the following: 1. Diagnosis of Cushing's Syndrome 2. Pituitary surgery is not an option 3. Treatment failure to one of the following ketoconazole, mitotane, or cabergoline	✓	✓	✓	✓	✓	✓	✓	✓
ivermectin 1% cream (Soolantra)	Coverage requires the following: 1. Trial and failure, contraindication, or intolerance to generic topical metronidazole 2. Trial and failure, contraindication, or intolerance to generic oral tetracycline, generic doxycycline or generic minocycline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Iyuzeh	Coverage requires the following: 1. For the reduction of elevated intraocular pressure (IOP) 2. Age ≥ 18 years old 3. Trial and failure of two preferred or generic benzalkonium chloride-free medications for the treatment of glaucoma Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Jatenzo	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication or intolerance to one generic or preferred testosterone product (examples include generic Androgel and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Joenja	Coverage requires the following: 1. Diagnosis of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) with an associated PI3Kδ mutation a. Documented variant in either PIK3CD or PIK3R1 2. Documented symptoms associated with APDS such as: a. Nodal and/or extranodal lymphoproliferation, history of repeated oto-sino-pulmonary infections and/or organ dysfunction (e.g. lung, liver) 3. Age ≥ 12 years old 4. Member will not use concurrently with an immunosuppressive medication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Jornay PM	Coverage requires the following: 1. Diagnosis of attention deficit hyperactivity disorder (ADHD) 2. Age ≥ 6 years old 3. Trial and treatment failure or intolerance to one generic stimulant, such as a generic amphetamine product or a generic methylphenidate product Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Juxtapid	Coverage requires the following: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) 2. Receiving optimal adjunctive therapies including a low-fat diet and other lipid-lowering treatments 3. Trial and treatment failure of Repatha Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Kalydeco	Coverage requires the following: 1. Diagnosis of Cystic Fibrosis (CF) 2. FDA approved gene mutation confirmed by genetic testing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Karbinal ER / Carbinoxamine malaete ER	Coverage requires trial and treatment failure to generic carbinoxamine and two other generic antihistamines Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Kerendia	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of chronic kidney disease associated with type 2 diabetes 3. Being used to reduce the risk of renal function decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Ketoprofen 25mg	Coverage requires the following: 1. Diagnosis of osteoarthritis OR 1. Diagnosis of pain OR 1. Diagnosis of primary dysmenorrhea OR 1. Diagnosis of rheumatoid arthritis	✓	✓	✓	✓	✓	✓	✓	✓

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Kevzara	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure with one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq, Simponi, or Xeljanz/XR 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia OR 1. Diagnosis of polymyalgia rheumatica 2. Age ≥ 18 years old 3. History of treatment with corticosteroids at a dose of > 10 mg per day prednisone equivalent for at least 8 weeks 4. Inadequate response or intolerance to corticosteroids as demonstrated by a disease flare during corticosteroid taper OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis 2. Weight ≥ 63 kg 3. Trial and treatment failure with one DMARD after a minimum 3-month trial unless contraindicated or not tolerated. Examples include: methotrexate, leflunomide 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq, or Xeljanz 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia Kevzara will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Kineret	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	OR 1. Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) with phenotype: Neonatal-onset multisystem inflammatory disease (NOMID) 2. Laboratory evidence of a genetic mutation OR elevated inflammatory markers plus at least two of six typical CAPS manifestations: (urticaria-like rash, cold-triggered episodes, hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, or skeletal abnormalities) OR 1. Diagnosis of Still's disease: including adult onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (sJIA) 2. Trial and treatment failure of one of the following therapies: glucocorticoids or NSAIDs OR 1. Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) 2. Laboratory evidence of homozygous genetic mutations of IL1RN **(criteria continued next page)**								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kineret (continued)	OR 1. Diagnosis of recurrent pericarditis (RP) 2. Age ≥ 12 years old 3. Trial and treatment failure or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs) in combination with colchicine Kineret will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Klisyri	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis (AK) on the face or scalp 3. Trial and treatment failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% Initial approval: 60 days Renewal requires lesion recurrence and/or the presence of new lesions	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kyzatrex	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Levorphanol	Coverage requires the following: 1. When used for as needed pain: Treatment failure or intolerance to three generic immediate release opioids (examples include, but not limited to: tramadol, morphine, hydrocodone, and oxycodone containing products) OR 1. When used for chronic pain requiring around-the-clock analgesia: Treatment failure or intolerance to three generic long-acting opioids. Examples include but are not limited to: buprenorphine transdermal patch, tramadol extended release, morphine extended release, fentanyl, methadone. Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
l-glutamine (Endari)	Coverage requires the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 5 years old 3. Prescribed by or in consultation with a hematologist 4. Patient has experienced 2 or more sickle cell-related crises in the past 12 months 5. Trial and treatment failure for at least 6 months, contraindication, or intolerance to hydroxyurea 6. Trial and failure of over-the-counter (OTC) L-glutamine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
liraglutide (Victoza)	Coverage requires the following: 1. For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes 2. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist-containing products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, and that the member is not experiencing serious adverse events from the medication	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Litfulo	Coverage requires the following: 1. Diagnosis of severe Alopecia Areata (AA), defined as ≥ 50% scalp hair loss OR 21-49% scalp hair loss with at least one of the following: a. Significant impact on psychosocial functioning resulting from AA b. Eyebrow or eyelash involvement c. Inadequate response to previous treatment after at least 6 months d. Diffuse (multifocal) positive hair pull test consistent with rapidly progressive AA 2. Age ≥ 12 years old Litfulo will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Livmarli	Coverage requires the following: 1. Treatment of cholestatic pruritus in patients with a diagnosis Alagille syndrome (ALGS) confirmed by documentation of ONE of the following: a. Genetic testing shows presence of the JAG1 or NOTCH2 genetic mutation b. Liver biopsy shows bile duct scarcity c. Involvement of 3 of 7 of the main organ systems affected in ALGS: hepatic, ocular, skeletal, vascular, facial, cardiac, or renal involvement 2. Age ≥ 3 months old 3. No history of liver transplant or planned future transplant 4. No clinical evidence of decompensated cirrhosis 5. Trial and failure, contraindication, or intolerance to generic ursodiol OR 1. Treatment of cholestatic pruritis in patients with progressive familial intrahepatic cholestasis (PFIC) i. Genetic testing does NOT show the presence of the ABCB11 variants resulting in a nonfunctional or complete absence of the bile salt export pump protein (BSEP-3) 2. Age ≥ 12 months old 3. No history of liver transplant or planned future transplant 4. No clinical evidence of decompensated cirrhosis 5. Trial and failure, contraindication, or intolerance to generic ursodiol 6. Trial and failure, contraindication, or intolerance to Bylvay Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Livtencity	Coverage requires the following: 1. Diagnosis of post-transplant cytomegalovirus (CMV) infection/disease 2. Age ≥ 12 years old and weight ≥ 35 kg 3. Trial and treatment failure of one of the following: ganciclovir, valganciclovir, cidofovir or foscarnet Initial approval: 3 months	✓	✓	✓	✓	✓	✓	✓	✓
luliconazole	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure of 2 topical over-the-counter antifungal agents 3. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lumryz	Coverage requires the following: 1. Diagnosis of narcolepsy and cataplexy 2. Age ≥ 7 years old 3. Trial and failure, contraindication, or intolerance to Wakix when age appropriate OR 1. Diagnosis of narcolepsy and excessive daytime sleepiness 2. Age ≥ 7 years old 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine, AND Wakix 4. For adults only- Trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi Lumryz will not be approved if patient is being treated with sedative hypnotic agents, other central nervous system (CNS) depressants or using alcohol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lupkynis	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of active lupus nephritis (LN) in combination with a background immunosuppressive therapy regimen 3. Must have active disease of the kidney confirmed on biopsy 4. Previous treatment courses of the following have been ineffective unless contraindicated or not tolerated: cyclophosphamide plus glucocorticoids OR mycophenolate mofetil plus glucocorticoids 5. Trial and failure, contraindication, or intolerance to Benlysta Initial approval: 6 months Initial renewal requires that the member is experiencing clinical benefit (for example, a stabilization or improvement in glomerular filtration rate (GFR) or at least a 50% reduction in proteinuria) Renewal approval: 1 year Subsequent renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Lybalvi	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lyvispah	Coverage requires the following: 1. Diagnosis of spasticity 2. Trial of baclofen tablets OR 2. Member is unable to swallow tablets Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Mavenclad	Coverage requires trial and failure or intolerance to one generic or preferred medication for the treatment of multiple sclerosis (MS) such as Avonex, Bafiertam, Betaseron, Copaxone, Kesimpta, or Vumerity Initial approval: 2 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Mavyret	Coverage requires the following: 1. Age ≥ 3 years old 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of the preferred medication: Epclusa or Zepatier 5. Patients with HCV genotype 1 who have previously been treated with regimens containing an NS5A (nonstructural protein 5A) inhibitor or an NS3/4A protease inhibitor, but not both 6. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure to Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
meloxicam capsule (Vivlodex)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of osteoarthritis 3. Trial and failure of generic Mobic (meloxicam tablet) 4. Trial and failure of two other preferred oral NSAIDs Initial approval: 1 year	✓	✓	**NC**	✓	✓		✓	**NC**
memantine/donepezil (Namzaric)	Coverage requires the following: Already stable on memantine (Namenda) and donepezil (Aricept) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
metformin hcl extended release (Fortamet)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of type 2 diabetes mellitus 3. Trial and treatment failure or intolerance to generic Glucophage XR (metformin extended release) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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methylergonovine (Methergine)	Coverage requires the following: 1. Management of uterine atony, hemorrhage, and subinvolution of the uterus following delivery of the placenta or control of uterine hemorrhage following delivery of the anterior shoulder in the second stage of labor OR 1. Being used for the prevention of migraine headaches 2. Member has persistent history of recurring debilitating headaches (4 or more headache days per month with migraine headache lasting for 4 hours per day or longer) 3. Trial and treatment failure after a minimum of 2 month trial, contraindication, or intolerance to three of the following: a. Anticonvulsants b. ACE inhibitors or angiotensin receptor blockers c. Beta blockers d. Calcium channel blockers e. Antidepressants f. Botulinum toxin 4. Trial and treatment failure after a minimum 2 month trial, contraindication, or intolerance to at least one calcitonin gene related peptide (CGRP) antagonist (such as: Aimovig, Ajovy, Emgality, or Vyepti) OR 1. Being used for the treatment of episodic or chronic cluster headache 2. Trial and failure, contraindication, or intolerance to at least three of the following: suboccipital steroid injection, verapamil, lithium, melatonin, frovatriptan, prednisone, or topiramate 3. Trial and failure, contraindication, or intolerance to Emgality Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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mifepristone (Korlym)	Coverage requires the following: 1. Member is ≥ 18 years of age 2. Diagnosis of hypercortisolism as a result of endogenous Cushing's Syndrome 3. Diagnosis of type II diabetes mellitus (DM) or glucose intolerance secondary to hypercortisolism. 4. Surgical treatment has been ineffective or not a candidate for surgery 5. Treatment failure or intolerance to a steroidogenesis inhibitor (such as ketoconazole, mitotane, or cabergoline), unless contraindicated 6. Failure to achieve adequate blood glucose control with maximally titrated therapy with an antidiabetic agent given for at least 3 months and which does not include metformin 7. Documentation of baseline 2 – hour glucose tolerance test if diagnosis is glucose intolerance. 8. HbA1c is required if diagnosis is type II DM Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
miglustat (Zavesca, Yargesa)	Coverage requires the following: 1. Age ≥ 18 years old 2. For the treatment of mild to moderate Gaucher disease type 1 (GD1) 3. Confirmation of diagnosis by biochemical assay showing decreased glucocerebrosidase activity in white blood cells or skin fibroblasts AND genotyping revealing two pathogenic mutations of the glucocerebrosidase gene 4. Two symptomatic manifestations of the disease are present, such as anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly 5. Trial and failure, contraindication, or intolerance to enzyme replacement therapy (ERT) OR 1. Age ≥ 4 years old 2. Diagnosis of Niemann-Pick Type C disease (NPC) confirmed via one of the following: a. Genetic confirmation of biallelic pathogenic or likely pathogenic mutations in the NPC1 or NPC2 genes b. One pathogenic or likely pathogenic mutation in the NPC1 or NPC2 genes and either a positive filipin staining test or elevated cholestane triol/oxysterols c. Two variants of uncertainty in the NPC1 or NPC2 genes and either a positive filipin staining test or elevated cholestane triol/oxysterols 3. Must present with neurological manifestations of NPC, such as, hypotonia, developmental delays, speech delay, dysphagia, ataxia, abnormal eye movements, and/or cataplexy Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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mirabegron ER tablets (Myrbetriq)	Coverage requires the following: 1. Diagnosis of overactive bladder (OAB) 2. Age ≥ 18 years old 3. Trial and treatment failure or intolerance to two preferred therapies for OAB OR 1. Diagnosis of neurogenic detrusor overactivity (NDO) 2. Weight ≥ 35 kg 3. Trial and treatment failure or intolerance to two generic anticholinergic agents for the treatment of NDO Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Mounjaro	Coverage requires the following: 1. For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes 2. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist-containing products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, and that the member is not experiencing serious adverse events from the medication	✓	✓	✓	✓	✓	✓	✓	✓

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Motpoly XR	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Weight ≥ 50 kg 3. Trial and failure, contraindication, OR intolerance to TWO generic alternatives for the treatment of seizures 4. Trial and failure, contraindication, OR intolerance to generic Vimpat tablet or solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	NC	✓	✓		✓	NC
Muse	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	NC	✓			✓	NC
Myalept	Coverage requires the following: 1. Replacement therapy to treat the complications of leptin deficiency, in addition to diet, in patients with congenital or acquired generalized lipodystrophy. 2. Optimally treated with insulin 3. Optimally treated with a statin (examples include atorvastatin, simvastatin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Mycapssa	Coverage requires the following: 1. Diagnosis of acromegaly 2. Previously tried, responded to, and tolerated generic immediate-release octreotide or lanreotide Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Myfembree	Coverage requires the following: 1. Management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women 2. Age ≥ 18 years old 3. Trial of two hormone related therapies OR 1. Treatment of pain associated with endometriosis in premenopausal women 2. Age ≥ 18 years old 3. Trial of two hormone related therapies Myfembree will be approved for a maximum of two years	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Myrbetriq granules	Coverage requires the following: 1. Diagnosis of neurogenic detrusor overactivity (NDO) 2. Age ≥ 3 years old 3. Trial and treatment failure or intolerance to two generic anticholinergic agents for the treatment of NDO OR 3. Member cannot swallow tablets/capsules AND has tried and failed an anticholinergic medication available as a solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Mytesi	Coverage is provided for the symptomatic relief of noninfectious diarrhea in patients with HIV/AIDS and on antiretroviral therapy	✓	✓	✓	✓	✓	✓	✓	✓
Naftifine gel (Naftin)	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure to two topical over-the-counter antifungal agents 3. Treatment failure to two oral generic antifungal agents Approval: 60 days	✓	✓	**NC**	✓			✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Natesto	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication or intolerance to one generic or preferred testosterone product (examples include generic Androgel and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Neupro	Coverage requires the following: 1. Diagnosis of Parkinson's disease 2. Treatment failure or intolerance to generic Mirapex (pramipexole) and generic Requip (ropinirole) OR 1. Diagnosis of Restless legs syndrome 2. Treatment failure or intolerance to generic Mirapex (pramipexole), generic Requip (ropinirole) and generic Neurontin (gabapentin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**				✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nexletol	Coverage requires the following: 1. Diagnosis of established cardiovascular disease (CVD), high risk for a CVD event but without established CVD, primary hyperlipidemia, or heterozygous familial hypercholesterolemia (HeFH) 2. Age ≥ 18 years old AND 3. Trial with one high intensity statin at maximum tolerated dose OR 3. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR 3. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nexlizet	Coverage requires the following: 1. Diagnosis of established cardiovascular disease (CVD), high risk for a CVD event but without established CVD, primary hyperlipidemia, or heterozygous familial hypercholesterolemia (HeFH) 2. Age ≥ 18 years old AND 3. Trial with one high intensity statin at maximum tolerated dose OR 3. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR 3. History of rhabdomyolysis after a trial of one statin (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Nicotrol, Nicotrol NS	Coverage for $0 copayment requires the following: 1. Trial and failure of 2 preferred agents such as generic bupropion extended release (Zyban), nicotine patch, nicotrine gum, nicotine lozenge 2. Age ≥ 18 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
nilutamide (Nilandron)	Coverage requires the following: 1. Treatment of metastatic prostate cancer in combination with surgical castration 2. Trial and failure, contraindication, or intolerance to generic Casodex (bicalutamide)	✓	✓	✓	✓			✓	✓
nitisinone (Orfadin)	Coverage requires the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	✓	✓	✓	✓	✓	✓	✓	✓
Nityr	Coverage requires the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	✓	✓	✓	✓	✓	✓	✓	✓
Nocdurna	Coverage requires the following: 1. Diagnosis of nocturnal polyuria 2. Lifestyle changes have been tried (including limiting fluids, elevation of legs) 3. Treatment failure or intolerance to one generic medication for overactive bladder (OAB) 4. Trial of generic oral desmopressin Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Noctiva	Coverage requires the following: 1. Diagnosis of nocturnal polyuria 2. Age ≥ 50 years old 3. Lifestyle changes have been tried (including limiting fluids such as water, alcohol and caffeine, elevation of legs) 4. Treatment failure or intolerance to one generic medication for over active bladder (OAB) (examples tolterodine, oxybutynin) 5. Trial of generic oral desmopressin	✓	✓	**NC**	✓	✓		✓	**NC**
Nourianz	Coverage requires the following: 1. Treatment of intermittent OFF episodes in patients with Parkinson's Disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Using in combination with carbidopa/levodopa Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucala	Coverage requires the following: 1. Diagnosis of severe uncontrolled eosinophilic asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Severe eosinophilic asthma identified by: a. Blood eosinophils greater than or equal to 150 cells/microliter at initiation of treatment AND b. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: i. LABA (long acting inhaled β2 agonist) OR ii. or leukotriene modifier OR iii. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old OR 1. Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) 2. Age ≥18 years old 3. Consult with an allergist/immunologist prior to initiation of Nucala therapy 4. History or presence of asthma 5. Presence of at least 2 of the following criteria that are typical of EGPA: histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation, neuropathy, pulmonary infiltrates, allergic rhinitis and nasal polyps, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura, or antineutrophil cytoplasmic antibody (ANCA) positivity **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucala (continued)	OR 1. Diagnosis of hypereosinophilic syndrome (HES) 2. Age ≥ 12 years old 3. At least 2 HES flares within the past 12 months (defined as HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy 4. Stable on HES therapy for at least 4 weeks (examples include: oral corticosteroids, immunosuppressive or cytotoxic therapy) 5. Eosinophil counts of 1,000 cells/microL or higher at initiation of therapy 6. Member does not have eosinophilia of unknown clinical significance, non-hematologic secondary HES (drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy), or F1P1L1-PDGFRa kinase-positive HES OR 1. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) 2. Age > 18 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. CRSwNP is recurring despite previous treatment with intranasal corticosteroids Nucala will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Approval length: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucynta	Coverage requires the following: 1. Diagnosis of acute pain 2. Age ≥ 6 years old and weight ≥ 16kg 3. Treatment failure or intolerance to three generic immediate release opioids (examples include, but not limited to: tramadol, morphine, hydrocodone, and oxycodone containing products) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucynta ER	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) 3. Trial and failure or intolerance to Xtampza ER OR 1. Diagnosis of Diabetic Peripheral Neuropathy (DPN) AND 2. If the member is equal to or greater than 65 years of age: Trial and failure of generic gabapentin (Neurontin) AND generic duloxetine (Cymbalta) OR 3. If the member is less than 65 years of age: Trial and failure of generic gabapentin (Neurontin) and generic duloxetine (Cymbalta) and a tricyclic antidepressant such as amitriptyline, desipramine, nortriptyline or imipramine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓	✓	✓	✓
Nuedexta	Coverage requires the following: 1. Diagnosis of pseudobulbar affect (PBA) 2. Presence of an underlying neurological condition causing symptoms of PBA (ex. Multiple Sclerosis, amyotrophic lateral sclerosis, Parkinson's Disease, stroke, traumatic brain injury)	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nuplazid	Coverage requires the following: 1. Diagnosis of Parkinson's disease psychosis Initial approval: 1 year Renewal requires clinically significant improvement in psychosis symptoms	✓	✓	✓	✓	✓	✓	✓	✓
Nurtec ODT	Coverage requires the following: 1. For acute treatment of migraine 2. Age ≥ 18 years old 3. Treatment failure or contraindication with 2 generic triptan medications OR 1. For preventive treatment of migraine headaches 2. Age ≥ 18 years old 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Not to be used in combination with other CGRP antagonists for migraine prevention Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Nyvepria	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ocaliva	Coverage requires the following: 1. Diagnosis of primary biliary cholangitis (PBC) confirmed by 2 of the 3 following American Association for the Study of Liver Diseases (AASLD) criteria i. Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) activity ii. Presence of antimitochondrial antibody (AMA) or other PBC-specific autoantibodies if AMA is negative iii. Histologic evidence of PBC seen on biopsy 2. Age ≥ 18 years old 3. Treatment with ursodeoxycholic acid (UDCA) at a dose of 13-15 mg/kg/day is ineffective after at least one year or not tolerated or use is contraindicated 4. Ocaliva is administered with UDCA unless UDCA has been not tolerated or is contraindicated 5. Not to be used in combination with additional second-line therapy for PBC (i.e. a peroxisome proliferator-activated receptor (PPAR) agonist) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Odactra	Coverage requires the following: 1. 5 to 65 years of age 2. Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by a positive skin test or in vitro testing for IgE antibodies to house dust mites 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Ofev	Coverage requires the following: 1. Treatment of idiopathic pulmonary fibrosis (IPF) OR 1. Treatment of declining pulmonary function in patients with systemic sclerosis-associated interstitial lung disease OR 1. Treatment of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ohtuvayre	Coverage requires the following: 1. Diagnosis of chronic obstructive pulmonary disease (COPD) 2. Age ≥ 18 years old 3. Trial and failure of dual therapy with a long-acting beta-2 agonist (LABA) and long-acting muscarinic antagonist (LAMA) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Olpruva	Coverage requires the following: 1. Diagnosis of urea cycle disorder 2. Will be used as adjunctive therapy to dietary management (such as dietary protein restriction and/or amino acid supplementation) 3. Trial and treatment failure of Buphenyl® (sodium phenylbutyrate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Olumiant	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of preferred tocilizumab biosimilar and Orencia OR 1. Diagnosis of severe Alopecia Areata (AA), defined as ≥ 50% scalp hair loss OR 21-49% scalp hair loss with at least one of the following: i. Significant impact on psychosocial functioning resulting from AA ii. Eyebrow or eyelash involvement iii. Inadequate response to previous treatment after at least 6 months iv. Diffuse (multifocal) positive hair pull test consistent with rapidly progressive AA 2. Age ≥ 18 years old Olumiant will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Omnaris	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Onapgo	Coverage requires the following: 1. For the treatment of motor fluctuations in advanced Parkinson's disease (PD) 2. Age ≥ 18 years old 3. Member must be established on and responsive to a levodopa-containing treatment regimen 4. Current treatment regimen must include at least one of the following in addition to levodopa-based therapy: a. Dopamine agonist b. Catechol-o-methyltransferase (COMT) inhibitor c. Monoaminoxidase-B (MAO-B) inhibitor d. Amantadine 5. Motor fluctuations are inadequately controlled by current treatment regimen, with member experiencing an average of at least 2.5 hours of "off" time per day Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Onzetra Xsail	Coverage requires the following: 1. Treatment failure or intolerance to generic Imitrex (sumatriptan) nasal spray and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)) OR 1. Age 12-17 years old 2. Treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Opsumit	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓
Opsynvi	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (PAH, WHO Group I) 2. WHO functional class (FC) II-III 3. Age ≥ 18 years old 4. Trial and failure, intolerance, or contraindication to ALL of the following: i. Generic sildenafil or tadalafil ii. Generic ambrisentan AND bosentan OR 4. Member is currently stable on individual components of Opsynvi being used in combination Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Opzelura	Coverage requires the following: 1. Diagnosis of atopic dermatitis (AD) 2. Age ≥ 12 years old 3. Trial and treatment failure with one topical steroid 4. Trial and treatment failure with generic Protopic (tacrolimus) or generic Elidel (pimecrolimus) 5. Trial and treatment failure with Eucrisa 6. Cannot be used in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine OR 1. Diagnosis vitiligo 2. Age ≥ 12 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure with generic Protopic (tacrolimus) or generic Elidel (pimecrolimus) 5. Not to be used in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants such as azathioprine or cyclosporine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Oralair	Coverage requires the following: 1. Age 5 through 65 years old 2. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in this product 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Oracea, doxycycline IR DR	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) AND generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Orencia SC	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, Rinvoq, or Xeljanz/XR OR 1. Diagnosis of polyarticular Juvenile Idiopathic Arthritis (pJIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one DMARD after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq/LQ, or Xeljanz/oral solution OR 1. Diagnosis of Psoriatic Arthritis 2. Age 2 to 5 years old 3. Trial and treatment failure of Enbrel and Rinvoq/LQ OR 2. Age 6 to 17 years old 3. Trial and treatment failure of two of the following: Enbrel, Rinvoq/LQ and preferred ustekinumab biosimilar OR 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Simponi, preferred ustekinumab biosimilar, Rinvoq/LQ, Skyrizi, Tremfya, or Xeljanz/XR Orencia will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Orenitram	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓
Orgovyx	Coverage requires the following: 1. Age ≥ 18 years old	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	2. Diagnosis of advanced prostate cancer 3. Trial and failure, contraindication, OR intolerance to Firmagon (covered under medical benefit)								
Oriahnn	Coverage requires the following: 1. Management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women 2. Age ≥18 years old 3. Trial of two hormone related therapies 4. Trial of Myfembree Oriahnn will be approved for a maximum of two years	✓	✓	✓	✓	✓	✓	✓	✓
Orilissa	Coverage requires the following: 1. Treatment of pain associated with endometriosis 2. Trial of two hormone related therapies 3. Age ≥ 18 years old. 150mg: Approval length 2 years 200mg: Approval length 6 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Orkambi	Coverage requires the following: 1. Age ≥ 1 year old 2. Diagnosis of cystic fibrosis (CF) 3. Presence of two copies of the F508del mutation confirmed by genetic test Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Orladeyo	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of hereditary angioedema (HAE) 3. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal referencerange (normal range ≥ 41%) 4. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 5. Prescribed by an immunologist, allergist or hematologist 6. Not to be used in combination with other products indicated for HAE prophylaxis Initial approval: 1 year Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR the severity of HAE attacks was reduced by 50% or more	✓	✓	✓	✓	✓	✓	✓	✓

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orlistat (Xenical)	Coverage requires the following: 1. Age ≥ 18 years old 2. BMI ≥ 30 kg/m2 or ≥ 27 kg/m2 with one related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products Initial approval: 6 months Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI ≥ 18.5 kg/m2 must be submitted to the plan for review	✓	✓	**NC**	✓			✓	**NC**
orphenadrine/aspirin /caffeine (Norgesic)	Coverage requires the following: 1. Treatment of acute pain 2. Age ≥ 12 years old 3. Trial and failure or intolerance to at least 3 preferred generic skeletal muscle relaxants, one of which must be generic Norflex (orphenadrine) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	**NC**	**NC**	✓				**NC**	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Otezla	Coverage requires the following: 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Psoriasis 2. Age ≥ 6 years old with weight at least 20 kg 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of oral ulcers associated with Behcet disease 2. Age ≥ 18 years old 3. Trial and treatment failure to one topical steroid for oral ulcers such as triamcinolone paste Otezla will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Otrexup	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ovidrel	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit			✓				✓	✓
oxcarbazepine extended-release (Oxtellar XR)	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic oxcarbazepine (Trileptal) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Oxervate	Coverage requires the following: Diagnosis of neurotrophic keratitis that has progressed to stage 2 or 3 Approval: 90 days	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
oxiconazole (Oxistat)	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure to two topical over-the-counter antifungal agents 3. Treatment failure to two oral generic antifungal agents Approval: 60 days	✓	✓	✓	✓			✓	✓
oxymorphone HCl ER (Opana ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ozempic	Coverage requires the following: 1. For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes 2. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist-containing products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, and that the member is not experiencing serious adverse events from the medication	✓	✓	✓	✓	✓	✓	✓	✓
Ozobax / baclofen	Coverage requires the following: 1. Diagnosis of spasticity 2. Trial and failure or intolerance to baclofen tablets OR member is unable to swallow tablets 3. Trial and failure or intolerance to Lyvispah Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Palforzia	Coverage for maintenance treatment requires the following: 1. FDA approved indication 2. Completion of all dose levels of up-dosing before starting maintenance OR 1. Stable on maintenance dose Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Palynziq	Coverage requires the following: 1. Diagnosis of phenylketonuria 2. Age ≥ 18 years old 3. Following a phenylalanine-restricted diet 4. Phenylalanine concentration ≥ 600 umol/liter 5. Trial and failure of generic sapropterin (requires prior authorization) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Pancreaze	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Pertzye	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
phentermine/ topiramate ER (Qsymia)	Coverage requires the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products OR 1. 12 to 17 years of age 2. BMI ≥ 95th percentile, standardized for age and sex 3. Current weight (within 30 days) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products Initial approval: 6 months For adults, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI ≥ 18.5 kg/m2 must be submitted to the plan for review For pediatrics, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 3% reduction in BMI from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI-for-age percentile ≥ 5th percentile must be submitted to the plan for review	✓	✓	NC	✓	✓	✓	✓	NC

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Pheburane	Coverage requires the following: 1. Diagnosis of urea cycle disorder 2. Will be used as adjunctive therapy to dietary management (such as dietary protein restriction and/or amino acid supplementation) 3. Trial and treatment failure of Buphenyl (sodium phenylbutyrate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
phenoxy-benzamine HCl (Dibenzyline)	Coverage is provided for the treatment of hypertension and sweating episodes due to pheochromocytoma: Age ≥ 18 years old **Preoperative treatment:** for members who have experienced treatment failure of or intolerance to a preferred selective alpha1-adrenergic receptor blocker (such as Cardura (doxazosin)) in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)) Approval: 60 days **Non-preoperative treatment:** for members who have experienced treatment failure of or intolerance to TWO selective alpha1-adrenergic receptor blockers (such as Cardura (doxazosin)) where both are used in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
pitavastatin (Livalo)	Coverage requires treatment failure or intolerance to at least two generic statins (examples include atorvastatin, rosuvastatin, simvastatin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓
Pregnyl	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice. 2. The member's benefit provides for coverage for infertility medications 3. Coverage may be provided in accordance with your medical fertility benefit For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males OR 2. Prepubertal cryptorchidism not caused by anatomic obstruction	✓	✓	✓	✓	✓		✓	✓
Procysbi	Coverage requires the following: 1. Treatment of nephropathic cystinosis 2. Has had a positive response to oral cysteamine (Cystagon) but has experienced intolerable side effects	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Prodigy Voice Glucose Meter	Coverage is provided when the member is visually impaired Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
prucalopride (Motegrity)	Coverage requires the following: 1. Trial and treatment failure or intolerance to lactulose or polyethylene glycol 2. Trial and treatment failure or intolerance to Linzess Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Pulmozyme	Coverage requires a diagnosis of cystic fibrosis	✓	✓	✓	✓	✓	✓	✓	✓
pyrimethamine (Daraprim)	Coverage is provided for the treatment of toxoplasmosis when used conjointly with a sulfonamide	✓	✓	✓	✓	✓	✓	✓	✓
Pyrukynd	Coverage requires the following: 1. Diagnosis of hemolytic anemia with pyruvate kinase (PK) deficiency 2. Age ≥ 18 years old 3. Must have clinical manifestations of disease, including, but not limited to, decreased hemoglobin (Hgb), increased reticulocytes, bilirubin, and/or lactate dehydrogenase (LDH) levels AND either one of the following: i. Serum assay showing a decrease of pyruvate kinase activity OR ii. Genetic testing showing at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene Initial approval: 6 months Renewal requires improvement in pyruvate kinase (PK) deficiency, including, but not limited to, improvement in Hgb, hemolysis laboratory results, and transfusion requirements	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Qbrexza	Coverage requires the following: 1. Treatment of primary axillary hyperhidrosis 2. Age ≥ 9 years of age 3. Trial of Drysol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Qelbree	Coverage requires the following: 1. Diagnosis of attention deficit hyperactivity disorder (ADHD) 2. Age ≥ 6 years old 3. Trial and treatment failure or intolerance to TWO generic or preferred products for the treatment of ADHD, at least one of which must be a nonstimulant OR 3. Member cannot swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Qnasl	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Quillichew ER	Coverage requires the following: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation OR 2. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, methylphenidate ER or generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Quillivant XR	Coverage requires the following: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation OR 2. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, methylphenidate ER or generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Qulipta	Coverage requires the following: 1. For preventive treatment of migraine headaches 2. Age ≥ 18 years old 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Not to be used in combination with other CGRP antagonists for migraine prevention Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Quviviq	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Radicava ORS	Coverage requires the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Prescribed by or in consultation with a neurologist 3. Start of treatment is within 2 years of diagnosis with amyotrophic lateral sclerosis (ALS) OR 3. After 2 years of diagnosis, with a percent predicted vital capacity value of ≥ 80% 4. Submission of a baseline metrics from the ALSFRS-R (Revised ALS Functional Rating Scale) 5. Currently receiving treatment and will continue to receive treatment with Riluzole, if tolerated Initial approval: 1 year Renewal requires submission of patient assessments using the ALSFRS-R or other clinical documentation, to determine if Radicava is slowing the progression of ALS	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ragwitek	Coverage requires the following: 1. Age 5 through 65 years old 2. Diagnosis of short ragweed pollen induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
raloxifene (Evista)	Coverage for $0 copayment will be provided when: 1. The member is a woman, at least 35 years of age and post-menopausal 2. The medication is being used for prevention of primary breast cancer in members classified as high risk 3. Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE)	✓	✓	✓	✓	✓		✓	✓
Rasuvo	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ravicti	Coverage requires the following: 1. Diagnosis of urea cycle disorder 2. Will be used as adjunctive therapy to dietary management (such as dietary protein restriction and/or amino acid supplementation) 3. Trial and treatment failure of Buphenyl (sodium phenylbutyrate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Rayos	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis 2. Trial or intolerance of two systemically absorbed generic oral corticosteroids, one of which must be prednisone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**		✓		✓	**NC**
Rebif	Coverage requires trial and failure or intolerance to two generic or preferred medications for the treatment of multiple sclerosis (examples include: Avonex, Bafiertam, Betaseron, Copaxone, Kesimpta, and Vumerity) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Recorlev	Coverage requires the following: 1. Treatment of endogenous hypercortisolemia in patients with Cushing's syndrome for whom surgery is not an option or has not been curative 2. Age ≥ 18 years old 3. Trial and treatment failure, contraindication, or intolerance to ketoconazole, mitotane, or cabergoline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Repatha	Coverage requires the following: 1. Diagnosis of primary hyperlipidemia, or prevention of cardiovascular events in patients with established cardiovascular disease a. Age ≥ 18 years old b. Trial and failure of one high intensity statin OR b. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR b. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) c. Not to be used in combination with other PCSK9 inhibitors OR 2. Diagnosis of homozygous familial hypercholesterolemia or heterozygoius familial hypercholesterolemia a. Age ≥ 10 years old b. Trial and treatment failure with one high intensity statin OR b. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR b. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) c. Not to be used in combination with other PCSK9 inhibitors Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Revcovi	Coverage requires the following: 1. Diagnosis of adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) 2. Prescribed by or in consultation with an immunologist 3. Confirmation of diagnosis by serum assay showing a decrease of adenosine deaminase activity followed by genetic testing showing a mutation in the adenosine deaminase gene 4. Treatment failure of or not a suitable candidate for a bone marrow transplant Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Rexulti	Coverage requires the following: 1. Treatment of schizophrenia 2. Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) OR 1. Treatment of agitation associated with dementia due to Alzheimer's disease OR 1. Adjunctive treatment of major depressive disorder (MDD) 2. Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Reyvow	Coverage requires the following: 1. Age ≥ 18 years old 2. For the acute treatment of migraines 3. Trial and treatment failure, contraindication, or intolerance to 2 generic triptan medications 4. Trial and treatment failure, contraindication, or intolerance to Ubrelvy and Nurtec ODT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List

Rezdiffra	Coverage requires the following:
	
	1. Age ≥ 18 years old
	2. Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction-associated steatohepatitis (MASH)
	3. Presence of advanced liver fibrosis (stage F2 to F3) verified by FibroScan or other imaging-based non-invasive liver disease assessment
	4. Using in conjunction with diet and exercise
	5. For members with BMI >27 kg/m2, documentation of active participation for a minimum of 3 months in a lifestyle modification program
	6. Member does not drink alcohol
	
	Initial approval: 1 year
	Renewal requires that current criteria are met AND
	• Member has not progressed to cirrhosis AND
	• That the medication is providing clinical benefit demonstrated by ONE of the following:
	  ○ NASH/ MASH resolution and no worsening of fibrosis
	  ○ Improvement in fibrosis by ≥ 1 stage with no worsening of NASH/ MASH or that the medication is providing clinical benefit
	  ○ Improvement or stabilization of NASH/ MASH demonstrated by imaging or blood based non-invasive liver disease assessment
		✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rhopressa	Coverage requires the following: 1. Trial of one generic medication, such as generic Xalatan, generic Lumigan, timolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Rinvoq tablet	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 2 years old 3. Weight ≥ 30kg 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis 2. Age ≥ 2 years old 3. Weight ≥ 30 kg 4. Trial and failure of at least 3 months of one DMARD unless contraindicated or not tolerated. Examples include methotrexate and leflunomide 5. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	1. Diagnosis of moderate to severe Atopic Dermatitis 2. Age ≥ 12 years old 3. Weight ≥ 40 kg 4. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil 5. Cannot be used in combination with other biologic agents indicated for severe atopic dermatitis OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure to one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Non-Radiographic Axial Spondyloarthritis with objective signs of inflammation 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s)								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	Rinvoq will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								
Rinvoq LQ	Coverage requires the following: 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 2 years old 3. Weight ≥ 10 kg 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis 2. Age ≥ 2 years old 3. Weight ≥ 10 kg 4. Trial and failure of at least 3 months of one DMARD unless contraindicated or not tolerated. Examples include methotrexate and leflunomide 5. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Rinvoq LQ will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rivfloza	Coverage requires the following: 1. Diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by genetic testing of the AGXT mutation 2. Age ≥ 2 years old 3. Patient has an estimated glomerular filtration rate (eGFR) ≥ 30 ml/min/1.73 m2 4. Patient does not have a history of kidney or liver transplant 5. Trial and failure (for at least 3 months), contraindication, OR intolerance to a course of high-dose vitamin B-6 therapy 6. Will not be used in combination with Oxlumo Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Rocklatan	Coverage requires the following: 1. Trial of one generic medication, such as generic Xalatan, generic Lumigan, timolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Rolvedon	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ruconest	Coverage requires the following: 1. Treatment of acute attacks of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. Prescribed by an immunologist, allergist or hematologist 4. Trial and treatment failure of generic Firazyr (icatibant) 5. Not to be used in combination with other products indicated for acute HAE attacks Initial approval: 1 year Renewal requires objective data documenting at least 50% improvement in time to relief of symptoms of acute attacks and maintenance of improvement of symptoms	✓	✓	✓	✓	✓	✓	✓	✓
rufinamide tablet (Banzel)	Coverage requires the following: 1. Treatment of seizures associated with Lennox-Gastaut syndrome 2. Age ≥ 1 year old 3. Trial and failure, contraindication, OR intolerance to two generic alternatives for the treatment of Lennox-Gastaut Syndrome Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ryaltris	Coverage requires trial and failure or intolerance to 1 generic intranasal steroid product after a minimum 3-month trial Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		**NC**	**NC**
Rybelsus	Coverage requires the following: 1. For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes 2. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist-containing products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, and that the member is not experiencing serious adverse events from the medication	✓	✓	✓	✓	✓	✓	✓	✓
Ryplazim	Coverage requires the following: 1. Diagnosis of plasminogen deficiency type 1 (hypoplasminogenemia) 2. Plasminogen activity level ≤45% Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Rytary	Coverage requires trial and treatment failure of generic Sinemet CR Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sancuso	Coverage requires the following: 1. Using for prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy 2. Treatment/failure with generic ondansetron (Zofran)/ODT and generic granisetron (Kytril)	✓	✓	✓	✓	✓	✓	✓	✓
sapropterin (Kuvan)	Coverage requires the following: 1. Treatment of phenylketonuria (PKU) 2. Following a phenylalanine-restricted diet	✓	✓	✓	✓	✓	✓	✓	✓
Savella	Coverage requires the following 1. Diagnosis of fibromyalgia 2. Treatment failure or intolerance to gabapentin 3. Treatment failure or intolerance to 3 of the following: a. Tricyclic antidepressant b. Selective serotonin reuptake inhibitor (SSRI) c. Serotonin norepinephrine reuptake inhibitor (SNRI) d. Cyclobenzaprine (Flexeril) e. Tramadol (Ultram) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓				✓	✓
Saxenda	Coverage criteria is determined by group benefit and requires one of the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	3. Current weight (within 30 days) must be submitted to the plan for review 4. Prescriber attests that the patient has been actively participating in lifestyle modifications that supports weight loss (e.g., diet, exercise, nutritional counseling, etc) for at least the past 6 months 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products OR 1. 12 to 17 years of age 2. BMI corresponding to 30 or greater for adults 3. Current weight (within 30 days) above 132 lb (60 kg) must be submitted to the plan for review 4. Prescriber attests that the patient has been actively participating in lifestyle modifications that supports weight loss (e.g., diet, exercise, nutritional counseling, etc) for at least the past 6 months 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products Initial approval: 6 months For adults, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 4% weight loss from baseline AND 1. Current weight (within 30 days) and BMI ≥ 18.5kg/m2 must be submitted to the plan for review 2. Continued participation in lifestyle modifications 3. Documentation that the member is not experiencing serious adverse events from the medication 4. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products For pediatrics, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 1% reduction in BMI from baseline AND 1. Current weight (within 30 days) and BMI-for-age percentile ≥ 5th percentile must be submitted to the plan for review 2. Continued participation in lifestyle modifications 3. Documentation that the member is not experiencing serious adverse events from the medication 4. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products **OR** coverage requires documentation of the following: 1. Age ≥ 18 years old 2. Body mass index (BMI) ≥ 35 kg/m2 3. Documentation of current (within 30 days) baseline weight								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	4. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan 5. Must be prescribed by a PCP or provider who has an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health 6. Not to be used in combination with other weight loss products 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products 8. Will not be covered for members with Type 2 Diabetes Mellitus OR 1. 12 to 17 years of age 2. BMI corresponding to 30 or greater for adults 3. Current weight (within 30 days) above 132 lb (60 kg) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products Initial approval: 6 months Continued coverage for adults may be provided if the member has maintained at least a 5% weight loss from baseline AND 1. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan AND 2. Must be prescribed by a PCP or provider, with an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health AND 3. Current weight (within 30 days) must be submitted to the plan for review AND 4. Patient's BMI was ≥ 35 kg/m2 prior to starting treatment, current BMI ≥ 18.5kg/m2 AND 5. Patient must have a proportion of days covered ≥ 80% AND								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	6. Not to be used in combination with other weight loss products AND 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products AND 8. Will not be covered for members with Type 2 Diabetes Mellitus Continued coverage for pediatrics will be reviewed annually and may be provided if the member has maintained at least a 1% reduction in BMI from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI-for-age percentile ≥ 5th percentile must be submitted to the plan for review. Saxenda cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products **Proof of active engagement requires at a minimum: documentation that the member has met with a Teladoc weight management coach and the member has a plan of action								
Secuado	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Serostim	Coverage requires the following: 1. Diagnosis of AIDS wasting cachexia 2. Age ≥ 18 years old 3. Unexplained weight loss > 10% of baseline 4. Concomitant anti-viral therapy for the duration of treatment	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sertraline HCl capsule	Coverage requires that the member has been stable on generic sertraline tablets at a dose of 150 mg or 200 mg daily for at least 3 months Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Signifor	Coverage requires the following: 1. Treatment of hypercortisolism as a result of endogenous Cushing's syndrome 2. Surgical treatment has not been effective or is not an option 3. Treatment failure or intolerance to ketoconazole, mitotane, or cabergoline, unless contraindicated Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Siklos	Coverage requires the following: 1. Diagnosis of sickle cell anemia 2. Age ≥ 2 years old 3. Unable to swallow capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sildenafil citrate suspension (Revatio)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) when the member is unable to swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓				✓	✓
sildenafil citrate tablet (Revatio)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit			✓					✓
sildenafil (Viagra)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Simlandi	Coverage requires the following: 1. Diagnosis of Psoriatic Arthritis 2. 2. Age ≥ 18 years old OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR 1. Diagnosis of polyarticular Juvenile Idiopathic Arthritis (pJIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old	✓	✓	✓	✓			✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	OR 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 6 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated OR 1. Diagnosis of Ulcerative Colitis 2. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated OR 1. Diagnosis of Hidradenitis Suppurativa 2. Previous 3-month trial of oral antibiotics OR 1. Diagnosis of Noninfectious Uveitis 2. Trial of an oral corticosteroid 3. Trial of an oral immunomodulatory agent (examples include methotrexate, azathioprine, cyclosporine) Adalimumab will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Simponi	Coverage requires the following: 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated Simponi will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Sirturo	Coverage requires the following: 1. Age ≥ 5 years old and weighting at least 15 kg 2. Treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB)	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Skyclarys	Coverage requires the following: 1. Diagnosis of Friedreich's ataxia 2. Age ≥ 16 years old 3. Confirmation of diagnosis via genetic testing revealing two pathogenic mutations of the frataxin (FXN) gene Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Skyrizi	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated Skyrizi will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sodium oxybate (Xyrem)	Coverage requires a diagnosis of narcolepsy AND: 1. Age ≥ 7 years of age 2. Cataplexy 3. Trial and failure, contraindication, or intolerance to Wakix when age appropriate OR 2. Excessive daytime sleepiness, AND 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine, AND Wakix 4. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi Xyrem will not be approved if patient is being treated with sedative hypnotic agents, other CNS depressants or using alcohol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Sohonos	Coverage requires the following: 1. Age ≥ 8 years old for females OR age ≥ 10 years old for males 2. Diagnosis of fibrodysplasia ossificans progressiva (FOP) confirmed by genetic testing showing an ACVR1 mutation, for the reduction in the volume of new heterotopic ossification (HO) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Somavert	Coverage requires diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sotyktu	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Otezla, Skyrizi, preferred ustekinumab biosimilar, or Tremfya Sotyktu will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) approved for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sovaldi tablets	Coverage requires the following: If cirrhosis is present: documentation of decompensated or compensated cirrhosis AND one of the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Trial of preferred medication: Epclusa or Zepatier 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C OR 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 2 or 3 3. Using in combination with ribavirin Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sovaldi oral pellets	Coverage requires the following: If cirrhosis is present: documentation of decompensated or compensated cirrhosis AND one of the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Trial of preferred medication: Epclusa or Zepatier 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C OR 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 2 or 3 3. Using in combination with ribavirin Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Spevigo	Coverage requires the following: 1. For the prevention of Generalized Pustular Psoriasis (GPP) as defined by the European Rare and Severe Psoriasis Expert Network 2. Age ≥ 12 years old 3. Weight ≥ 40 kg 4. A GPPGA total score of 0 or 1 5. A history of at least 2 past moderate-to-severe GPP flares with new or worsening pustulation 6. Trial of at least one of the following systemic therapies for the prevention of GPP flares and continued to experience GPP flares either during treatment, following dose reduction, or following/within one year of treatment discontinuation, unless contraindicated or not tolerated: acitretin, methotrexate, cyclosporine, infliximab 7. Not to be used in combination with other biologics or targeted DMARDs Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Spritam	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Member is unable to swallow tablets or capsules 3. Trial of 3 generic or preferred alternatives, one of which must be generic levetiracetam (Keppra) solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Staxyn	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Stendra	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Stimufend	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓		✓	✓
Strensiq	Coverage requires the following: 1. Diagnosis of perinatal/infantile and juvenile-onset hypophosphatasia. 2. < 18 years old at onset of symptoms 3. Diagnosis confirmed by one or two pathogenic variants in the ALPL gene + 4. Must have documentation of active disease manifestations such as: skeletal malformations/fractures, respiratory difficulties, dental manifestations, kidney damage, or seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Subsys	Coverage requires the following: 1. Medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long-acting opioid 4. Treatment failure or intolerance to oral immediate release narcotics (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Sucraid	Coverage is provided for the treatment of congenital sucrase-isomaltase deficiency	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sumatriptan succinate/ naproxen sodium (Treximet)	Coverage requires the following: 1. Treatment failure or intolerance to generic sumatriptan (Imitrex) and naproxen used in combination 2. Treatment failure or intolerance to a second generic triptan (Maxalt, Amerge, Zomig/ZMT) OR 1. Age 12-17 years old 2. Treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Sunosi	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA) 3. For a diagnosis of OSA: Nonpharmacologic treatment has been initiated (ex. CPAP) 4. Trial and treatment failure of modafinil or armodafinil 5. Trial and treatment failure of one generic or preferred treatment such as methylphenidate or dextroamphetamine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Symdeko	Coverage requires the following: 1. Age ≥ 6 years old 2. Diagnosis of cystic fibrosis (CF) 3. Presence of two copies of the F508del mutation OR at least one mutation in the CFTR gene that is responsive to Symdeko as confirmed by genetic test Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Sympazan	Coverage requires the following: 1. Diagnosis of Lennox-Gastaut syndrome 2. Trial of generic clobazam tablets AND generic clobazam solution OR 2. Documentation that the member is unable to swallow tablets/capsules/solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
tadalafil (Adcirca, Alyq)	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tadalafil (Cialis)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Tadliq	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Member is unable to swallow tablets 3. Trial and failure, intolerance or contraindication to generic sildenafil suspension Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Takhzyro	Coverage requires the following: 1. Diagnosis of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with the following laboratory findings: i. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) ii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥41%) 3. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 4. Prescribed by an immunologist, allergist or hematologist 5. Not to be used in combination with other products indicated for HAE prophylaxis Initial approval: 1 year Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR the severity of HAE attacks was reducted by 50% or more	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Taltz	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 6 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of one of the following: Enbrel, preferred adalimumab biosimilar, Skyrizi, preferred ustekinumab biosimilar, or Tremfya OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one of the following: Enbrel, preferred adalimumab biosimilar, Simponi, preferred ustekinumab biosimilar, Rinvoq/LQ, Skyrizi, Tremfya, or Xeljanz/XR OR 1. Diagnosis of active Non-Radiographic Axial Spondyloarthritis with objective signs of inflammation 2. Age ≥ 18 years old 3. Trial and treatment failure of Cimzia or Rinvoq OR 1. Diagnosis of active Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of Enbrel, preferred adalimumab biosimilar, Simponi, Xeljanz/XR, or Rinvoq Taltz will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tamoxifen	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer in members classified as high risk 3. Does not have a history of breast cancer 4. Does not have a family or personal history of venous thromboembolic events (VTE)	✓	✓	✓	✓	✓		✓	✓
Tarpeyo	Coverage requires the following: 1. Intended to reduce the loss of kidney function for the diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of disease progression 2. Age ≥ 18 years old 3. Trial and failure to maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy unless contraindicated 4. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone, or prednisone Initial approval: 9 months	✓	✓	✓	✓	✓	✓	✓	✓
Tascenso ODT	Coverage requires the following: 1. Diagnosis of multiple sclerosis (MS) 2. Age ≥ 10 years old 3. Will not be used in combination with other disease-modifying treatments for multiple sclerosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tasimelteon (Hetlioz**)**	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of Non-24-hour sleep-wake disorder in patients who are totally blind and unable to perceive light 3. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND Rozerem (ramelteon) OR 1. Age ≥ 16 years old 2. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by genetic testing showing deletion of chromosome 17p11.2 OR mutation in the retinoic acid-induced 1 (RAI1) gene 3. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND acebutolol 4. For adults only- Trial and failure, contraindication, or intolerance to Rozerem (ramelteon) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Tavneos	Coverage requires the following: 1. Adjunctive treatment of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) in combination with standard therapy including glucocorticoids 2. Age ≥ 18 years old 3. Must be initiated in combination with a standard therapy regimen that includes either cyclophosphamide plus glucocorticoids or rituximab/rituximab biosimilar plus glucocorticoids Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tavalisse	Coverage requires the following: Diagnosis of chronic immune thrombocytopenia (IT) and persistent thrombocytopenia (platelet count < 100,000mcl) for ≥ 3 months and all of the following: 1. Age ≥ 18 years old 2. Trial and treatment failure or not a candidate for treatment with corticosteroids, immunoglobulins or splenectomy 3. Current platelet count is < 20,000 mcl or < 30,000 mcl and symptoms of active bleeding 4. Trial of generic eltrombopag (Promacta) Initial approval: 3 months Renewal requires a stable platelet count of at least 50,000/mcL	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
teriparatide (Forteo)	Coverage requires the following: 1. Diagnosis of osteoporosis with a T-score of less than or equal to -2.5, history of a fragility fracture, or high FRAX fracture probability (defined as a 10-year major osteoporotic fracture risk greater than or equal to 20% or hip fracture risk greater than or equal to 3%) 2. If member has very high-risk osteoporosis: Trial and failure (such as reduction of T-score or fracture) of zoledronate OR if zoledronate is contraindicated a preferred denosumab product i. Very high risk meets ONE of the following criteria: 1. Recent fracture (e.g., within the past 12 months) 2. Fractures while on approved osteoporosis therapy 3. Multiple fractures 4. Fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) 5. Very low T-score (e.g., less than − 3.0 6. High risk for falls or history of injurious falls 7. Very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%) or other validated fracture risk algorithm 3. If member is high risk: Trial and failure (such as reduction of T-score or fracture) of oral or IV bisphosphonates AND a preferred denosumab product unless contraindicated Initial approval: 2 years Use of Forteo for more than 2 years should only be considered if high risk for fracture remains or has returned	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Testosterone, topical Androgel, generic Androge, generic Testim, generic Vogelxo	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Testosterone, topical generic Axiron, generic Fortesta Testosterone 10mg (2%) Testosterone 30mg Testosterone 50mg (1%)	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tezspire	Coverage requires the following: 1. Diagnosis of eosinophilic asthma 2. Age ≥ 12 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3-month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) OR 1. Diagnosis of allergic asthma 2. Age ≥ 12 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3-month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tezspire (Continued)	OR a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) OR 1. Diagnosis of oral corticosteroid dependent asthma 2. Age ≥ 12 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3-month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tezspire (Continued)	OR 1. Diagnosis of severe asthma 2. Age ≥ 12 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3-month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) Tezspire will not be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Teglutik	Coverage requires the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Trial of generic riluzole tablets OR 2. Difficulty swallowing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tiopronin (Thiola)	Coverage requires the following: 1. For the prevention of cystine stone formation in patients weighing ≥ 20 kilograms 2. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalization Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
tiopronin (Thiola EC)	Coverage requires the following: 1. For the prevention of cystine stone formation in patients weighing ≥ 20 kilograms 2. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalization Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Tlando	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication, or intolerance to one generic or preferred testosterone product (examples include generic Androgel, and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tobi Podhaler	Coverage requires the following: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa 2. Trial and failure of generic Tobi (tobramycin) inhalation nebulization solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
tolvaptan (Jynarque)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of autosomal dominant polycystic kidney disease (ADPKD) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
tolvaptan (Samsca)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of clinically significant hyponatremia 3. Hyponatremia is defined as serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction 4. Therapy is initiated/re-initiated in a hospital Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
topiramate ER (Qudexy XR)	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
topiramate extended release (Trokendi XR)	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Tracleer suspension	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tremfya	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of ulcerative colitis (UC) 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated Tremfya will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
trientine hydrochloride (Syprine)	Coverage requires the following: 1. Diagnosis of Wilson's disease Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Trikafta	Coverage requires the following: 1. Diagnosis of cystic fibrosis 2. Age ≥ 2 years old 3. Presence of at least one copy of the F508del mutation OR at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Trikafta as confirmed by genetic test 4. Member is not using Trikafta in combination with an additional CFTR potentiator such as: Orkambi, Kalydeco, or Symdeko Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Trintellix	Coverage requires trial and failure, contraindication, or intolerance to two antidepressant agents	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Trulicity	Coverage requires the following: 1. For the treatment of Type 2 Diabetes or trial of one generic or preferred medication for the treatment of Type 2 Diabetes 2. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist-containing products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, and that the member is not experiencing serious adverse events from the medication	✓	✓	✓	✓	✓	✓	✓	✓
Tryngolza	Coverage requires the following: 1. Diagnosis of familial chylomicronemia syndrome (FCS) 2. Age ≥ 18 years old 3. Diagnosis is confirmed by documentation of homozygote, compound heterozygote, or double heterozygote for loss-of-function mutations in FCS-causing genes, such as LPL, APOC2, APOA5, GPIHBP1, or LMF1 4. Fasting triglyceride level ≥ 880 mg/dL 5. Patient must follow a low-fat diet (≤ 20 grams of total fat per day) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tyenne	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq, Simponi, or Xeljanz/XR OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of two of the following: Enbrel, preferred adalimumab biosimilar, Rinvoq/LQ, or Xeljanz/oral solution OR 1. Diagnosis of Still's disease, including adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (sJIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one of the following therapies: glucocorticoids or NSAIDs OR 1. Diagnosis of giant cell arteritis 2. Age ≥ 18 years old OR 1. Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) 2. Inadequate response to (as evidenced by disease progression - (e.g. worsening of pulmonary function) or not a candidate for either mycophenolate mofetil OR cyclophosphamide Tyenne will not to be used in combination with other biologics or targeted DMARDs for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tymlos	Coverage requires the following: 1. Diagnosis of osteoporosis with a T-score of less than or equal to -2.5, history of a fragility fracture, or high FRAX fracture probability (defined as a 10-year major osteoporotic fracture risk greater than or equal to 20% or hip fracture risk greater than or equal to 3%) 2. If member has very high-risk osteoporosis: Trial and failure (such as reduction of T-score or fracture) of zoledronate OR if zoledronate is contraindicated a preferred denosumab product i. Very high risk meets ONE of the following criteria: 1. Recent fracture (e.g., within the past 12 months) 2. Fractures while on approved osteoporosis therapy 3. Multiple fractures 4. Fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) 5. Very low T-score (e.g., less than − 3.0 6. High risk for falls or history of injurious falls 7. Very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%) or other validated fracture risk algorithm 3. If member is high risk: Trial and failure (such as reduction of T-score or fracture) of oral or IV bisphosphonates AND a preferred denosumab product unless contraindicated Tymlos will be approved for a maximum of 2 years	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tyvaso/Tyvaso DPI	Coverage requires the following: 1. Treatment of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan OR 1. Treatment of pulmonary arterial hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Ubrelvy	Coverage requires the following: 1. For acute treatment of migraine 2. Age ≥ 18 years old 3. Treatment failure or contraindication with 2 generic triptan medications Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Udenyca	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓			✓	✓
Uptravi	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
vardenafil (Levitra)	May be covered for the diagnosis of erectile dysfunction dependent on the plans benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
Varubi	Coverage will be provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril) 2. Preferred NK1 antagonist (ex. Emend) 3. Glucocorticoid (dexamethasone)	✓	✓	✓	✓			✓	✓
Vecamyl	Coverage requires treatment failure with or intolerance to all of the following drug classes: 1. Diuretic 2. Beta-Blocker 3. Ace-inhibitor 4. Angiotensin II receptor blocker 5. Calcium channel blocker Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Ventavis	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓		✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Verkazia	Coverage requires the following: 1. Diagnosis of vernal keratoconjunctivitis 2. Age ≥ 4 years old 3. Trial and failure, or intolerance to a dual acting, topical antihistamine/mast-cell stabilizer such as epinastine, ketotifen and olopatadine 4. Trial and failure or intolerance to ophthalmic corticosteroids such as dexamethasone eye drops, Generic FML liquifilm, FML, FML forte, loteprednol and generic Pred Forte 5. Trial and failure or intolerance to generic Restasis OR 1. Diagnosis of vernal keratoconjunctivitis with compromised corneal epithelium/ corneal ulcers 2. Age ≥ 4 years old 3. Trial and failure or intolerance to generic Restasis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Veozah	Coverage requires the following: 1. Treatment of moderate-to-severe vasomotor symptoms due to menopause 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to one preferred or generic medication for the treatment of vasomotor symptoms Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Verquvo	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of chronic heart failure New York Heart Association (NYHA) Class II-IV 3. Left ventricular ejection fraction (LVEF) of less than 45% 4. History of ONE of the following: i. Previous hospitalization for heart failure within prior 6 months OR ii. Outpatient intravenous (IV) diuretic treatment for heart failure within prior 3 months 5. Taken in combination with at least TWO of the following unless contraindicated or not tolerated: i. Metoprolol succinate, carvedilol, or bisoprolol ii. An ACE-inhibitor (ACE, such as lisinopril), angiotensin receptor blocker (ARB, such as losartan), or angiotensin receptor-neprilysin inhibitor (ARNI, such as sacubitril/valsartan) iii. A sodium glucose cotransporter-2 (SGLT2) inhibitor approved for heart failure iv. A mineralocorticoid receptor antagonist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vesicare LS	Coverage requires the following: 1. Treatment of neurogenic detrusor overactivity (NDO) 2. Age ≥ 2 years old 3. Trial and failure of two anticholinergic drugs for the treatment of NDO OR 3. Physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed an anticholinergic medication available as a solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Viberzi	Coverage requires the following: 1. Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) 2. Trial and treatment failure, contraindication, or intolerance to a tricyclic antidepressant Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
vigabatrin powder (Sabril)	Coverage requires the following: 1. Diagnosis of infantile spasms OR 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and failure, contraindication, OR intolerance to three generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
vigabatrin tablet (Sabril)	Coverage requires the following: 1. Diagnosis of infantile spasms OR 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and treatment failure of three generic alternatives for seizure 3. Trial of Sabril powder Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vijoice 50 mg, 125 mg tablet **Vijoice granules**	Coverage requires the following: 1. Age ≥ 2 years old 2. Diagnosis of PIK3CA‑Related Overgrowth Spectrum (PROS) confirmed by detection of a PIK3CA mutation or based on clinical features suspected of PROS Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Viokace	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Vivjoa	Coverage requires the following: 1. Diagnosis recurrent vulvovaginal candidiasis (RVVC) in females with history of RVVC who are not of reproductive potential 2. Trial and failure, contraindication, or intolerance to generic oral fluconazole alone Approval: 12 weeks	✓	✓	**NC**	✓			✓	**NC**

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Voquezna	Coverage requires the following: 1. For the treatment of Helicobacter pylori (H. pylori) infection 2. Age ≥ 18 years old 3. Trial of a generic, guideline recommended, first-line regimen for H. pylori infection such as clarithromycin triple therapy (proton pump inhibitor (PPI) + clarithromycin + amoxicillin or metronidazole) or bismuth quadruple therapy (PPI + bismuth subcitrate or subsalicylate + tetracycline + metronidazole) OR 1. For the treatment of erosive esophagitis (EE) 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to three of the following generic or over the counter (OTC) PPIs: omeprazole (Prilosec), esomeprazole (Nexium), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex) OR 1. For the treatment of non-erosive gastroesophageal reflux disease (GERD) 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to three of the following generic or over the counter (OTC) PPIs: omeprazole (Prilosec), esomeprazole (Nexium), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex) Approval for H. pylori and non-erosive GERD: 60 days Approval for EE: 1 year	✓	✓	NC	✓	✓	✓	✓	NC

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vosevi	Coverage requires the following: 1. Age 18 years or older 2. For patients with chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection that have failed treatment regimen containing an NS5A (nonstructural protein 5A) inhibitor and have no liver damage or have liver damage and showing no symptoms from the damage 3. For patients with chronic hepatitis C genotype 1a or 3 that have previously failed sofosbuvir containing regimen without an NS5A inhibitor and have no liver damage or have liver damage and showing symptoms of the damage 4. Trial and failure to preferred medication: Epclusa or Zepatier 5. If treatment experienced, documentation of previous treatments for Hepatitis C 6. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓
Vowst	Coverage requires the following: 1. To prevent the recurrence of Clostridioides difficile infection (CDI) 2. Age ≥ 18 years old 3. Had at least 1 recurrence after a primary episode of CDI AND completed one or more round(s) of standard-of-care antibiotic therapy (ex: metronidazole, vancomycin, fidaxomicin) OR 3. Two or more episodes of severe CDI resulting in hospitalization within the past year 4. Positive C. difficile stool test with toxin A/B results within the previous 30 days 5. Not to be used in combination with other products for prevention of CDI, such as Zinplava™ or Rebyota® Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Voxzogo	Coverage requires the following: 1. Diagnosis of achondroplasia 3. Presence of fibroblast growth factor receptor 3 (FGFR3) gene mutation confirming diagnosis 4. Open epiphyses 5. Recent growth velocity and height (growth velocity must be > 1.5 cm/year) Initial approval: 1 year Renewal requires the presence of open epiphyses, and an updated height and growth velocity to show that growth has been maintained or increased from baseline	✓	✓	✓	✓	✓	✓	✓	✓
Voydeya	Coverage requires the following: 1. Age ≥ 18 years old 2. Using as add-on therapy to Ultomiris or Soliris for the treatment of extravascular hemolysis (EVH) with paroxysmal nocturnal hemoglobinuria (PNH) 3. Must have clinically significant extravascular hemolysis (EVH) due to paroxysmal nocturnal hemoglobinuria (PNH) with the following: i. Hemoglobin (Hgb) ≤ 9.5 g/dL ii. Absolute reticulocyte count ≥ 120 × 109/L 4. Must be used in combination with Soliris® or Ultomiris® only 5. Trial and failure, contraindication, or intolerance to Empaveli and Fabhalta Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vraylar	Coverage requires the following: 1. Trial and failure, contraindication, or intolerance to two preferred second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Vtama	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of plaque psoriasis 3. Trial and failure, contraindication, or intolerance to a generic medium or high potency topical corticosteroid 4. Trial and failure, contraindication, or intolerance to at least one of the following generic topical steroid-sparing agents: calcipotriene, tazarotene, tacrolimus, or pimecrolimus OR 1. Diagnosis of atopic dermatitis (AD) 2. Age ≥ 2 years old 3. Trial and failure, contraindication, or intolerance to one topical steroid 4. Trial and failure, contraindication, or intolerance to generic Protopic (tacrolimus) or generic Elidel (pimecrolimus) 5. Trial and failure, contraindication, or intolerance to Eucrisa Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vyalev	Coverage requires the following: 1. For the treatment of motor fluctuations in advanced Parkinson's disease (PD) 2. Age ≥ 18 years old 3. Member must be established on and responsive to a levodopa-containing treatment regimen 4. Current treatment regimen must include at least one of the following in addition to levodopa-based therapy: a. Dopamine agonist b. Catechol-o-methyltransferase (COMT) inhibitor c. Monoaminoxidase-B (MAO-B) inhibitor d. Amantadine 5. Motor fluctuations are inadequately controlled by current treatment regimen, with member experiencing an average of at least 2.5 hours of "off" time per day Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Vyleesi	Coverage requires the following: 1. Premenopausal female ≥ 18 years old 2. Diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that has been ongoing for more than 6 months 3. Other causes (such as relationship difficulty, substance abuse, medication side effects) of HSDD must be ruled out Initial approval: 60 days Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vyndamax	Coverage requires the following: 1. Diagnosis of wild-type or hereditary (variant) transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) confirmed by ONE of the following: a. A negative monoclonal light chain screen ruling out amyloid light chain cardiomyopathy AND Technetium-labeled bone scintigraphy, OR b. Endomyocardial biopsy with confirmatory transthyretin amyloid typing by mass spectrometry, immunoelectron microscopy, or immunohistochemistry 2. For hereditary ATTR-CM, diagnosis must also be confirmed by documentation of TTR gene mutation 3. Age ≥ 18 years old 4. Documentation of clinical signs and symptoms of ATTR-CM, including NYHA Class I, II, and III heart failure characterized by limited functional capacity and decline in quality of life Vyndamax will not be approved for use in combination with other therapies approved for transthyretin-mediated amyloidosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vyndaqel	Coverage requires the following: 1. Diagnosis of wild-type or hereditary (variant) transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) confirmed by ONE of the following: a. A negative monoclonal light chain screen ruling out amyloid light chain cardiomyopathy AND Technetium-labeled bone scintigraphy, OR b. Endomyocardial biopsy with confirmatory transthyretin amyloid typing by mass spectrometry, immunoelectron microscopy, or immunohistochemistry 2. For hereditary ATTR-CM, diagnosis must also be confirmed by documentation of TTR gene mutation 3. Age ≥ 18 years old 4. Documentation of clinical signs and symptoms of ATTR-CM, including NYHA Class I, II, and III heart failure characterized by limited functional capacity and decline in quality of life Vyndaqel will not be approved for use in combination with other therapies approved for transthyretin-mediated amyloidosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Vyzulta	Coverage requires the following: 1. Diagnosis of elevated intraocular pressure 2. Trial of all preferred medications (generic Xalatan, generic Lumigan, generic Travatan Z) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Wainua	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of peripheral nerve disease caused by hereditary transthyretin amyloidosis (hATTR; formerly known as familial amyloidosis polyneuropathy or FAP) with documented TTR mutation i. Signs and symptoms of ocular or cerebral area involvement (such as in ocular amyloidosis or primary/leptomeningeal amyloidosis), if present, must not predominate over polyneuropathy symptomology associated with hATTR 3. Documentation of clinical signs and symptoms of peripheral neuropathy (such as: tingling or increased pain in the hands, feet and/or arms, loss of feeling in the hands and/or feet, numbness or tingling in the wrists, carpal tunnel syndrome, loss of ability to sense temperature, difficulty with fine motor skills, weakness in the legs, difficulty walking) AND/OR 3. Documentation of clinical signs and symptoms of autonomic neuropathy symptoms (such as: orthostasis, abnormal sweating, dysautonomia [constipation and/or diarrhea, nausea, vomiting, anorexia, early satiety]) 4. Must have a baseline FAP or Coutinho Stage 1 or 2 5. No prior liver transplant 6. Must not have New York Heart Association (NYHA) heart failure classification > 2 Wainua will not be used in combination with other therapies approved for transthyretin-mediated amyloidosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Wakix	Coverage requires a diagnosis of narcolepsy AND: 1. Age ≥ 18 years old 2. Cataplexy OR 1. Age ≥ 6 years old 2. Excessive daytime sleepiness 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine 4. For adults only – trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Wegovy	Coverage criteria is determined by group benefit and requires one of the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Prescriber attests that the patient has been actively participating in lifestyle modifications that supports weight loss (e.g., diet, exercise, nutritional counseling, etc) for at least the past 6 months 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products OR 1. 12 to 17 years of age 2. BMI ≥ 95th percentile, standardized for age and sex 3. Current weight (within 30 days) must be submitted to the plan for review 4. Prescriber attests that the patient has been actively participating in lifestyle modifications that supports weight loss (e.g., diet, exercise, nutritional counseling, etc) for at least the past 6 months 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	Initial approval: 6 months For adults, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline AND 1. Current weight (within 30 days) and BMI ≥ 18.5kg/m2 must be submitted to the plan for review 2. Continued participation in lifestyle modifications 3. Documentation that the member is not experiencing serious adverse events from the medication 4. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products For pediatrics, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 1% reduction in BMI from baseline AND 1. Current weight (within 30 days) and BMI-for-age percentile ≥ 5th percentile must be submitted to the plan for review 2. Continued participation in lifestyle modifications 3. Documentation that the member is not experiencing serious adverse events from the medication 4. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing product **OR** coverage requires documentation of the following: 1. Age ≥ 18 years old 2. Body mass index (BMI) ≥ 35 kg/m2 3. Documentation of current (within 30 days) baseline weight 4. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan 5. Must be prescribed by a PCP or provider who has an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health 6. Not to be used in combination with other weight loss products 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products 8. Will not be covered for members with Type 2 Diabetes Mellitus OR 1. 12 to 17 years of age 2. BMI ≥ 95th percentile, standardized for age and sex								

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	3. Current weight (within 30 days) must be submitted to the plan for review 4. Active participation for a minimum of 6 months in a covered BCBSM/BCN lifestyle modification program OR active participation for a minimum of 6 months in an alternative concurrent lifestyle modification program (e.g. recent food diaries, exercise logs, app participation, etc.) if member does not have access to a covered BCBSM/BCN program 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1(GLP-1) agonist containing products Initial approval: 6 months Continued coverage for adults may be provided if the member has maintained at least a 5% weight loss from baseline AND 1. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan AND 2. Must be prescribed by a PCP or provider, with an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health AND 3. Current weight (within 30 days) must be submitted to the plan for review AND 4. Patient's BMI was ≥ 35 kg/m2 prior to starting treatment, current BMI ≥ 18.5kg/m2 AND 5. Patient must have a proportion of days covered ≥ 80% AND 6. Not to be used in combination with other weight loss products AND 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products AND 8. Will not be covered for members with Type 2 Diabetes Mellitus Continued coverage for pediatrics will be reviewed annually and may be provided if the member has maintained at least a 1% reduction in BMI from baseline AND requires continued participation in a lifestyle modification program. Current weight (within 30 days) and BMI-for-age percentile ≥ 5th percentile must be submitted to the plan for review. Wegovy cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products **Proof of active engagement requires at a minimum: documentation that the member has met with a Teladoc weight management coach and the member has a plan of action								

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Winlevi	Coverage requires the following: 1. Treatment of acne 2. Age ≥ 12 years old 3. Trial and failure contraindication, or intolerance to one oral agent (examples include: generic Monodox, generic Vibramycin, generic Minocin, generic Bactrim, or generic Aldactone) 4. Trial and failure contraindication, or intolerance to three topical agents (examples include: generic Benzaclin, generic Benzamycin, generic Retin-A, or generic Differin cream/gel) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Winrevair	Coverage requires the following: 1. For the treatment of pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening events 2. Age ≥ 18 years old 3. Trial and failure, intolerance, or contraindication to ALL of the following: a. Generic sildenafil or tadalafil AND b. A generic or preferred endothelin receptor antagonist (ERA) 4. The member will self-administer Winrevair unless clinically unable to do so Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xcopri	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Xdemvy	Coverage requires the following: 1. Diagnosis of Demodex blepharitis confirmed via the presence of collarettes upon examination with a slit lamp 2. Age ≥ 18 years old Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz tablet	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz tablet (continued)	OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Xeljanz tablet will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xeljanz solution	Coverage requires the following: 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure to one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Xeljanz solution will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz XR	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Xeljanz XR will not be used in combination with other biologics, targeted DMARDs, or other potent immunosuppressants like azathioprine or cyclosporine for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xelpros	Coverage requires the following: 1. Treatment of elevated intraocular pressure 2. Trial and treatment failure of two preferred medications such as generic Xalatan, Lumigan or Travatan Z Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Xelstrym	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (methylphenidate ER, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Xepi	Coverage requires the following: 1. Diagnosis of impetigo 2. Trial of generic Bactroban Approval: 60 days	✓	✓	**NC**	✓			✓	**NC**

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xifaxan 550mg	Coverage requires the following: 1. Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) 2. Trial and treatment failure, contraindication, or intolerance to a tricyclic antidepressant OR 1. Diagnosis of small intestinal bacterial overgrowth (SIBO) as detected by an appropriate breath test 2. Trial and failure of TWO generic antibiotics OR 1. Diagnosis of intestinal methanogen overgrowth (IMO) as detected by an appropriate breath test 2. Using in combination with neomycin unless contraindicated Initial approval for IBS-D and SIBO: 60 days IBS-D and SIBO/IMO renewal: requires the presence of recurrent symptoms after the completion of the prior course of treatment (maximum of 2 renewals will be provided in accordance with FDA label for IBS-D) OR 1. Diagnosis of hepatic encephalopathy (HE) 2. Trial and failure of lactulose Initial approval for HE: 1 year HE renewal: requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xolair	Coverage requires the following: 1. Diagnosis of uncontrolled moderate to severe allergic asthma 2. Age ≥ 6 years old** 3. Positive skin test or in-vitro reactivity to a perennial aeroallergen 4. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 5. IgE level > 30 but < 700 IU/ml for patients 12 years of age and older OR 5. IgE level > 30 but < 1300 IU/ml for patients between the ages of 6 to < 12 years old 6. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider OR 1. Diagnosis of chronic idiopathic urticaria 2. Documentation of diagnosis per the American Academy of Allergy Asthma and Immunology (AAAI) guidelines: a. Must have occurrence of almost daily hives and itching for at least 6 weeks 3. Age ≥ 12 years old **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

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Xolair (continued)	4. Past trial and failure all of the following for at least 2 months: a. Trial and failure of a second-generation antihistamine at the maximal tolerated dose for at least 2 months b. Trial and failure one of the following at maximal dosing: i. Another second-generation antihistamine ii. H2 antagonist iii. Leukotriene receptor antagonist iv. First generation antihistamine given at bedtime v. Hydroxyzine vi. Doxepin 5. Other diagnoses have been ruled out 6. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider OR 1. Diagnosis of nasal polyps 2. Age ≥ 18 years old 3. Patient is currently receiving and will continue to receive standard of care regimen 4. Inadequate response to treatment with intranasal corticosteroids 5. Baseline serum total IgE level of 30 IU/mL to 1,500 IU/mL prior to initiating treatment with Xolair 6. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider OR 1. Diagnosis of IgE-mediated food allergy 2. Age ≥ 1 year old** 3. Clinical history of allergic reaction following consumption of at least one of the following: peanuts, milk, eggs, wheat, cashews, hazelnuts, and walnuts 4. Confirmed diagnosis of an allergy to either peanuts, milk, eggs, wheat, cashews, hazelnuts, or walnuts confirmed by one of the following: a. IgE specific antibodies greater than or equal to 6 kUA/L b. Food-specific skin prick test (SPT) 5. Provider attestation that the member will be on an allergen avoidant diet while on Xolair therapy 6. Must have a current prescription for epinephrine and access to an epinephrine autoinjector while using Xolair 7. Serum total IgE level greater than 30 but less than or equal to 1850 IU/mL 8. Must not be used in combination with any other food allergy desensitization therapy Xolair will not be used in combination with other biologics or targeted DMARDs for the same indication **Xolair autoinjectors (all doses) are intended for use only in adults and adolescents aged 12 years and older Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xolremdi	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of WHIM (warts, hypogammaglobulinemia, infections, and myelokathexis) syndrome 3. Clinical diagnosis of WHIM syndrome with confirmed CXCR4 mutation 4. ANC < 400 cells/µL or total WBC count ≤400 cells/µL if ANC below lower limit of detection Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xphozah	Coverage requires the following: 1. Age ≥ 18 years old 2. For the reduction of serum phosphorus for the diagnosis of chronic kidney disease (CKD) on dialysis 3. Using as add on therapy for those with inadequate response to phosphate binders or intolerance of any dose of phosphate binder therapy Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xromi	Coverage requires the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 6 months old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xtampza ER	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time Initial appoval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓
Xuriden	Coverage requires the following: 1. Diagnosis of Hereditary Orotic Aciduria Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xyosted	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xywav	Coverage requires the following: 1. Age ≥ 7 years old 2. Diagnosis of narcolepsy and cataplexy 3. Trial and failure, contraindication, or intolerance to Wakix when age appropriate OR 1. Diagnosis of narcolepsy and excessive daytime sleepiness 2. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine, AND Wakix 3. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi OR 1. Age ≥ 18 years old 2. Diagnosis of idiopathic hypersomnia 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine 4. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil Xywav will not be approved if patient is being treated with sedative hypnotic agents, other central nervous system (CNS) depressants or using alcohol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Yesintek	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 6 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 6 years old OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated Yesintek will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Yorvipath	Coverage requires the following: 1. Treatment of hypoparathyroidism (HP) 2. Age ≥ 18 years old 3. Treatment with calcium and active vitamin D has been ineffective for disease control after a minimum of 12 weeks, unless contraindicated or not tolerated Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Zavzpret	Coverage requires the following: 1. For acute treatment of migraine 2. Age ≥ 18 years old 3. Trial and treatment failure, contraindication, or intolerance to 2 generic triptan medications, one of which must be a generic intranasal triptan 4. Trial and treatment failure, contraindication, or intolerance to to Ubrelvy and Nurtec ODT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zembrace SymTouch	Coverage requires the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Zepatier	Coverage requires the following: 1. Age ≥ 12 years old or weight ≥ 30 kilograms 2. Diagnosis of Chronic Hepatitis C genotype 1 or 4 3. For genotype 1a patients, test results for NS5a resistance-associated polymorphisms 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling	✓	✓	✓	✓	✓	✓	✓	✓
Zepbound	Coverage criteria is determined by group benefit and requires one of the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Prescriber attests that the patient has been actively participating in lifestyle modifications that supports weight loss (e.g., diet, exercise, nutritional counseling, etc) for at least the past 6 months 5. Not to be used in combination with other weight loss products 6. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products Initial approval: 6 months	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline AND 1. Current weight (within 30 days) and BMI ≥ 18.5kg/m2 must be submitted to the plan for review 2. Continued participation in lifestyle modifications 3. Documentation that the member is not experiencing serious adverse events from the medication 4. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products **OR** coverage requires documentation of the following: 1. Age ≥ 18 years old 2. Body mass index (BMI) ≥ 35 kg/m2 3. Documentation of current (within 30 days) baseline weight 4. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan 5. Must be prescribed by a PCP or provider who has an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health 6. Not to be used in combination with other weight loss products 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products 8. Will not be covered for members with Type 2 Diabetes Mellitus Initial approval: 6 months Continued coverage may be provided if the member has maintained at least a 5% weight loss from baseline AND 1. Documentation of active participation for a minimum of 6 months in a lifestyle modification program (e.g. recent food diaries documenting a caloric deficit or adherence to a low calorie or modified diet, OR exercise logs, step counter reports, gym attendance logs, app participation or fitness tracker printouts that demonstrate at least 10,000 steps per day or 150 minutes of moderate-intensity physical activity per week, etc.) and documentation of current active participation in Teladoc Health Weight Management Program** must be submitted to the plan AND 2. Must be prescribed by a PCP or provider, with an established relationship with the member, that the member has seen in-person for the evaluation and management of the member's overall health AND								

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
	3. Current weight (within 30 days) must be submitted to the plan for review AND 4. Patient's BMI was ≥ 35 kg/m2 prior to starting treatment, current BMI ≥ 18.5kg/m2 AND 5. Patient must have a proportion of days covered ≥ 80% AND 6. Not to be used in combination with other weight loss products AND 7. Cannot be used in combination with other glucagon-like peptide-1 (GLP-1) agonist containing products AND 8. Will not be covered for members with Type 2 Diabetes Mellitus **Proof of active engagement requires at a minimum: documentation that the member has met with a Teladoc weight management coach and the member has a plan of action								
Zeposia	Coverage requires the following: 1. Diagnosis of ulcerative colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for 7 days, immunomodulators such as azathioprine for at least 2 months) has been ineffective or is contraindicated or not tolerated 4. Trial and treatment failure of two of the following: preferred adalimumab biosimilar, Simponi, Skyrizi, preferred ustekinumab biosimilar, Tremfya, Xeljanz/XR, or Rinvoq OR 1. Diagnosis of multiple sclerosis 2. Age ≥ 18 years old Zeposia will not be used in combination with other biologics or targeted disease-modifying anti-rheumatic drugs (DMARDs) for the same indication Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zetonna	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		**NC**	**NC**

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zilbrysq	Coverage requires the following: 1. Diagnosis of generalized myasthenia gravis (gMG) 2. Age ≥ 18 years old 3. Documented anti-acetylcholine receptor (AChR) antibody positive myasthenia gravis (MG) identified by: a. Lab record or chart notes identifying the patient is positive for anti-AChR antibodies AND b. One of the following confirmatory tests: i. Positive edrophonium test ii. History of clinical response to oral cholinesterase inhibitors (for example: pyridostigmine) iii. Electrophysiological evidence of abnormal neuromuscular transmission by repetitive nerve stimulation (RNS) or single-fiber electromyography (SFEMG) 4. Patients must NOT have a history of: a. Thymectomy within 12 months b. Current thymoma c. Other neoplasms of the thymus 5. Previous treatment courses of at least 12 weeks with one of the following standards of care have been ineffective: methotrexate, azathioprine, cyclophosphamide, cyclosporine, mycophenolate mofetil, or tacrolimus unless all are contraindicated or not tolerated 6. Patient is currently receiving, and will continue to receive, a stable standard of care regimen 7. Must not be used with other biologic therapies for myasthenia gravis or immunoglobulin therapy Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
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* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
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		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zokinvy	Coverage requires the following: 1. Age ≥ 1 year old 2. Body surface area (BSA) ≥ 0.39 m^2 3. The requested dose is appropriate for the patient's current body surface area (BSA) 4. Diagnosis of Hutchinson-Gilford Progeria Syndrome (HGPS) confirmed by a mutation in the LMNA gene OR 4. Diagnosis of processing-deficient Progeroid Laminopathies with one of the following: i. Heterozygous LMNA gene mutation with progerin-like protein accumulation OR 1. Homozygous or compound heterozygous ZMPSTE24 gene mutations Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
zolmitriptan nasal spray (Zomig)	Coverage requires the following: 1. Trial and treatment failure or intolerance to two generic triptans (generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT tablets) OR 1. Age 12-17 years old 2. Trial and treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
zolpidem tartrate sublingual (Intermezzo)	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Zonisade	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Age ≥ 16 years old 3. Trial of 3 generic alternatives, one of which must be generic Zonegran (zonisamide) capsules OR 3. Member is unable to swallow tablets or capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zoryve 0.15% cream	Coverage requires the following: 1. Diagnosis of atopic dermatitis 2. Age ≥ 6 years old 3. Trial and treatment failure with one topical steroid 4. Trial and treatment failure with generic Protopic (tacrolimus) or generic Elidel (pimecrolimus) 5. Trial and treatment failure of Eucrisa Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Zoryve 0.3% cream	Coverage requires the following: 1. Diagnosis of plaque psoriasis 2. Age ≥ 6 years old 3. Trial and failure, contraindication, or intolerance to a generic medium or high potency topical corticosteroid 4. Trial and failure, contraindication, or intolerance to at least one of the following generic topical steroid-sparing agents: calcipotriene, tazarotene, tacrolimus, or pimecrolimus Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

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		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zoryve foam	Coverage requires the following: 1. Diagnosis of seborrheic dermatitis 2. Age ≥ 9 years old 3. Trial and failure, contraindication, or intolerance to at least two of the following generic or preferred agents: topical antifungal, topical corticosteroids, or topical calcineurin inhibitors Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Ztalmy	Coverage requires the following: 1. Diagnosis of seizures associated with cyclin‐dependent kinase‐like 5 (CDKL5) deficiency disorder 2. CDKL5 deficiency disorder confirmed by genetic testing showing mutations on the CDKL5 gene 3. Age ≥ 2 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

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Drug name	Current Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zurzuvae	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of postpartum depression (PPD) with an onset of depressive symptoms in the third trimester or within 4 weeks postpartum 3. Patient is currently ≤ 12 months postpartum 4. Will be used in combination with or a recommendation will be given for psychotherapy Approval: 60 days	✓	✓	✓	✓	✓	✓	✓	✓

We Speak Your Language
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.
Call 877-469-2583 TTY: 711 or speak to your provider.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.
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ھۆشیاربە: ئەگەر بە کوردی قسە دەکەیت، خزمەتگوزاریی یارمەتیدانی زمان بە خۆڕایی بۆ تۆ بەردەستە. هەروەها هاوکارییەکانی یارمەتیدان و خزمەتگوزاریی گونجاو بۆ دابینکردنی زانیاری بە شێوازە گەیشتنپێکراوەکان بە خۆڕایی بەردەستن. پەیوەندی بکە بە 877-469-2583 TTY: 711 یان قسە لەگەڵ دابینکەرەکەت بکە.
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.
VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.
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https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:
U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201
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