Blue Cross Blue Shield Blue Care Network of Michigan

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BCN Advantage[SM] HMO-POS and HMO
BCN Advantage Comprehensive Formulary
Prior Authorization / Step Therapy Program
2020 Plan Year
Updated 12/1/2020

BCN Advantage HMO-POS and HMO monitor the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization** (PA) for these drugs means that either clinical and/or administrative criteria must be met before coverage is provided. Drugs subject to **step therapy** (ST) may require previous treatment with one or more formulary drugs prior to coverage. Drugs that must meet clinical/administrative criteria are identified in the formulary list with (PA) or (ST). If drugs listed below have a **(g)** noted, the **PA** or **ST** criteria may also apply to the generic version of the drug. In some cases, the brand name drug is listed for reference and the generic drug is covered. Please refer to the Formulary to verify if your drugs are covered. Your physician can contact our pharmacy help desk to request prior authorization or step therapy for these drugs.

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

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

MEDICATION/ DRUG CLASS	CRITERIA
Abilify Maintena® (aripiprazole)	Coverage requires trial of oral aripiprazole. **Coverage duration:** Lifetime.
Adempas® (riociguat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Afinitor® (everolimus)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Afinitor Disperz® (everolimus)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Alecensa® (alectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Alpha-1 Proteinase Inhibitors **Zemaira®**	Requires documentation of a congenital deficiency of alpha-1 antitrypsin, demonstrated by a homozygous phenotype of AAT, and must have symptomatic emphysema and serum levels of alpha-1 antitrypsin that are less than 80mg/dl and must have deteriorating pulmonary function, as demonstrated by a decline in the fev1 (less than 65% of predictive value). For reauthorization must provide serum levels of alpha-1 antitrypsin that are above threshold of 80mg/dl. *All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Coverage duration:** Initial approval is for 6 months. Reauthorization is for 1 year.
Alunbrig™ (brigatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Amitiza® (lubiprostone)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Ampyra® (g) (dalfampridine)	Initial requests require documentation of a 25 foot timed walk test. Renewal of therapy requires documentation that the member has shown an improvement in walking distance of a 25 foot timed walk test compared to pretreatment. *All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing physician is a neurologist. **Exclusion criteria:** Patients with a history of seizure or moderate to severe renal impairment defined by a CrCl of 50ml/min or less. **Coverage duration:** Initial approval is for 3 months. Reauthorization is for 1 year.
Anabolic Steroids **Anadrol-50®** (oxymetholone) **Oxandrin® (g)** (oxandrolone)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided if anabolic steroids are used to enhance athletic performance or for anti-aging purposes. **Coverage duration:** 1 year.
Androgel® (g) (testosterone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Anti-diabetic agents **Farxiga ™** (dapagliflozin) **Invokana®** (canagliflozin) **Invokamet®, Invokamet® XR** (canagliflozin + metformin) **Xigduo XR™** (dapagliflozin + metformin)	Coverage requires the trial or intolerance to at least 1 of the following: metformin, a sulfonylurea, pioglitazone, or a DPP-4 inhibitor. **Coverage duration**: Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Anti-diabetic Injectable Agents **Byetta®** (exenatide) **Bydureon®** , **Bydureon® BCise™** (exenatide) **Victoza®** (liraglutide)	Coverage will be provided for patients who are currently taking or who have tried and failed one of the following: metformin, a sulfonylurea or a thiazolidinedione, or one of the following: a combination of metformin and a sulfonylurea or a combination of metformin and a thiazolidinedione. *All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided for a non-Type 2 diabetes diagnosis, or for weight loss in patients with or without diabetes. **Coverage duration:** Lifetime.
Antidepressants **Paxil® suspension** (paroxetine) **Trintellix®** (voritoxetine) **Fetzima™** (levomilnacipran) **Fetzima™ titration pack** (levominacipran) **Viibryd®** (vilazodone HCl)	Coverage requires a claim for at least one generic antidepressant agent in the past 120 days. **Coverage duration**: 1 year.
Antipsychotic Agents **Caplyta®** (lumateperone) **Adasuve®** (loxapine) **Fanapt®** (iloperidone) **Geodon®** (ziprasidone) **Latuda®** (lurasidone) **Saphris®** (asenapine) **Secuado®** (asenapine) **Vraylar™** (cariprazine) **Zyprexa® Relprevv™** (olanzapine)	Coverage requires the trial of at least one generic antipsychotic agent. **Coverage duration:** Lifetime.

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Apidra® (insulin glulisine)	Coverage requires the trial or intolerance to Novolin® 70/30, Novolin® N, Novolin® R, Novolog® 70/30 or Novolog®. **Coverage duration:** Lifetime.
Arcalyst® (rilonacept)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 12 years of age and older. **Coverage duration:** 1 year.
Arikayce® (amikacin liposome inhalation suspension)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Aristada™ (aripiprazole lauroxil)	Coverage requires the trial or intolerance to Abilify Maintena® or oral aripiprazole. **Coverage duration:** Lifetime.
Aristada Initio™ (aripiprazole lauroxil)	Coverage requires trial of oral aripiprazole. **Coverage duration:** Lifetime.
Aubagio® (teriflunomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Auryxia® (ferric citrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Avonex® **(**interferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Ayvakit™ (avapritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Balversa™ (erdafitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Berinert® (C1 inhibitor, human)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Betaseron® (interferon beta-1b)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime
Blenrep (belantamab mafodotin-blmf)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Bosulif® (bosutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Braftovi™ (encorafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Briviact® (brivaracetam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Brukinsa™ (zanubrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cablivi® (caplacizumab-yhdp)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cabometyx™ (cabozantinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Calquence® (acalabrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cayston® (aztreonam)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cholbam® (cholic acid)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.

MEDICATION/ DRUG CLASS	CRITERIA
Cometriq® (cabozantinib s-malate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Copiktra™ (duvelisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Cosentyx® (secukinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Cotellic™ (cobimetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Daliresp® (roflumilast)	Coverage is provided for the treatment of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis in patients with a history of exacerbations. Patient is receiving: 1. inhaled long-acting beta-2 agonist [for example, formoterol , salmeterol] AND 2. inhaled long-acting anticholinergic agent [for example, tiotropium] AND 3. inhaled corticosteroid [for example, fluticasone] OR If patient experienced intolerance or has contraindications to use of these medications. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Daurismo™ (glasdegib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Dojolvi™ (triheptanoin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Doptelet® (avatrombopag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Enbrel® (etanercept)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Enhertu® (fam-trastuzumab deruxtecan-nxki)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Enspryng™ (satralizumab-mwge)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Epclusa® (sofosbuvir/velpatasvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage Duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Epidiolex® (cannabidiol)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Erivedge® (vismodegib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescribers restrictions:** Prescribed by or in consultation with an Oncologist or Dermatologist. **Coverage duration:** 1 year.
Erleada™ (apalutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage Duration**: 1 Year.
Erythropoiesis Stimulating Agents **Aranesp®** (darbepoetin), **Epogen®** (epoetin alfa), **Procrit®** (epoetin alfa)	Erythropoiesis stimulating agents are subject to Part B versus Part D review. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 3 months.
Esbriet® (pirfenidone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Extavia® (interferon beta-1B)	Coverage requires trial of at least one of the following: Interferon Beta-1B (Betaseron®), Interferon Beta-1A (Avonex®), Peginterferon Beta-1A (Plegridy®) or Interferon Beta-1A (Rebif®) *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Farydak® (panobinostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Fintepla® (fenfluramine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Firazyr® (icatibant acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age and older. **Coverage duration:** 1 year.
Firdapse® (amifampridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Forteo® (teriparatide)	Coverage requires documentation of bone mineral density that is 2.5 standard deviations or more below the mean (T-score at or below -2.5). Coverage requires patient has tried and failed at least one bisphosphonate except when: 1. Contraindication to an oral and intravenous bisphosphonate (such as a stricture or aclasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration) OR 2. Documented intolerance to a bisphosphonate *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year with a maxiumim of 2 years of total therapy.
Galafold™ (migalastat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Gattex® (teduglutide)	Coverage requires documentation of dependence on parenteral support for 12 months or greater. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gavreto™ (pralsetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gilenya® (fingolimod hydrochloride)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Gilotrif® (afatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Growth Hormone (somatropin), **Humatrope®, Norditropin®, Nutropin®, Serostim®**	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** For pediatric patients, all indications must be prescribed by a pediatric endocrinologist or pediatric nephrologist. **Coverage duration:** Pediatrics: 1 year. Adults: Lifetime.
Haegarda® (C1 Inhibitor, Human)	*All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 6 years of age and older. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Harvoni™ (ledipasvir/sofosbuvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Hemady™ (dexamethasone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Hetlioz™ (tasimelteon)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
High Risk Drugs **Elavil® (g)** amitriptyline hydrochloride **Anafranil™ (g)** (clomipramine hydrochloride) doxepin hydrochloride **Tofranil™ (g)** (imipramine hydrochloride) imipramine pamoate thioridazine hydrochloride **Surmontil® (g)** (trimipramine maleate)	High risk tricyclic antidepressants are approved if patient has a history of use. For patients initiating therapy, the high risk tricyclic antidepressant is approved if at least one of the suggested alternatives (nortriptyline, desipramine, citalopram, escitalopram, mirtazapine, sertraline, venlafaxine) with less sedation and fewer anticholinergic effects have been tried and failed or are not appropriate or contraindicated for the intended use. Thioridizine is covered for patients who have a history of use. For patients inititating therapy, thioridizine is covered if patient has a failure of or intolerance to at least one other safer alternative antipsychotic such as aripiprazole or quetiapine. *All medically accepted indications not otherwise excluded from Part D.* **Age Restriction:** Authorization is required for members 65 years of age and older. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Humalog® (insulin lispro)	Coverage requires the trial of or intolerance to Novolog® 70/30 or Novolog®. **Coverage duration:** Lifetime.
Humira® (adalimumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Humulin® Insulin (Humulin® R, Humulin® N, Humulin® 70/30)	Coverage requires a trial of or intolerance to Novolin® 70/30, Novolin® N or Novolin® R. **Coverage duration:** Lifetime.
Ibrance® (palbociclib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Iclusig® (ponatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Idhifa® (enasidenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Imbruvica™ (ibrutinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Increlex® (mecasermin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Inlyta® (axitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Inqovi® (decitabine and cedazuridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Inrebic® (fedratinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Intranasal Steroids **Omnaris®** (ciclesonide)	Coverage requires a claim for 30 days of a generic nasal steroid spray or Beconase AQ in the past 120 days. **Coverage duration**: 1 year.
Invega Sustenna® (paliperidone palmitate)	Coverage requires the trial of oral paliperidone or oral risperidone. **Coverage duration:** Lifetime.
Invega Trinza™ (paliperidone palmitate)	Coverage requires the trial of oral paliperidone or oral risperidone. **Coverage duration:** Lifetime.
Jakafi® (ruxolitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions**: prescribing physician is an oncologist or hematologist. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Jynarque™ (tolvaptan)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Kalydeco™ (ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Kisqali® (ribociclib) **Kisqali® Femara® Co-Pack** (ribociclib & letrozole)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Korlym™ (mifepristone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Koselugo™ (selumetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Kuvan® (sapropterin hydrochloride)	Renewal requires initial therapy at least 2 months and a 30% or greater reduction in phenylalanine from baseline. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Initial: 2 months. Renewal: 1 year.
Lenvima™ (lenvatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Libtayo® (cemiplimab-rwlc)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lidoderm® Patch (g) (lidocaine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Livalo® (pitavastatin)	Coverage requires the trial of at least one generic statin. **Coverage duration:** Lifetime.
Lonsurf® (trifluridine and tipiracil)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Lorbrena® (lorlatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lotronex® (g) (alosetron)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lumoxiti™ (moxetumomab pasudotox-tdfk)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Lynparza™ (olaparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:**. 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Megace® (g) (megestrol)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Mekinist™ (trametinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:**. Lifetime.
Mektovi® (binimetinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Monjuvi™ (tafasitamab-cxix)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Movantik™ (Naloxegol Oxalate)	Coverage is provided for diagnosis of opioid induced chronic constipation with chronic, non-cancer pain. Member must be stable on opioid therapy for a minimum of 2 weeks. *All medically accepted indications not otherwise excluded from Part D.* **Age restrictions:** Patients 18 years of age or older. **Coverage duration:** Initial=3 months. Renewal=1 year.
Myalept® (metreleptin)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Prescribing physician is an endocrinologist. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Narcolepsy Agents **Nuvigil® (g)** (armodafinil) **Provigil® (g)** (modafanil)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Narcotic analgesics (fentanyl citrate) **Abstral®** **Actiq® (g)**	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Natpara® (parathyroid hormone, recombinant)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nerlynx™ (neratinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nexavar® (sorafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ninlaro® (ixazomib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Nityr™ (nitisinone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Nubeqa™ (darolutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Nuedexta® (dextromethorphan hydrobromide/quinidine sulfate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Nuplazid™ (pimavanserin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Odomzo® (sonidegib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Ofev® (nintedanib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Onureg® (azacitidine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Orencia® (abatacept)	Coverage for the diagnosis of rheumatoid arthritis requires trial of two of the following preferred agents: etanercept (Enbrel®), adalimumab (Humira®), or tofacitinib (Xeljanz®/Xeljanz® XR). Coverage for the diagnosis of juvenile idiopathic arthritis requires trial of both of the following preferred agents: etanercept (Enbrel®) and adalimumab (Humira®). Coverage for the diagnosis of psoriatic arthritis requires trial of two of the following preferred agents: secukinumab (Cosentyx®), etanercept (Enbrel®), adalimumab (Humira®), or tofacitinib (Xeljanz®/Xeljanz® XR). *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Orkambi® (ivacaftor/lumacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:**. Lifetime.
Oxbryta™ (voxelotor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Oxervate™ (cenegermin-bkbj)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Padcev™ (enfortumab vedotin-ejfv)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Palynziq™ (pegvaliase-pqpz)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pancreaze® (pancrelipase microtablets)	Coverae requires the trial of or intolerance to Creon®. **Coverage duration:** Lifetime.
Pemazyre™ (pemigatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Perseris™ (risperidone)	Coverage requires a trial of oral risperidone. **Coverage duration:** Lifetime.
Piqray® (alpelisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Plegridy® (peginterferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Polivy™ (polatuzumab vedotin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Pomalyst® (pomalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Praluent® (alirocumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Prolia® (denosumab)	Prolia is subject to Part B versus Part D review. Requires: Patient has tried and failed at least one bisphosphonate except when: 1. There is a contraindication to a bisphosphonate (oral and intravenous) such as a stricture or aclasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration 2. There is a documented intolerance to a bisphosphonate. *All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for hypocalcemia. **Coverage duration:** 1 year.
Promacta® (eltrombopag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Pulmonary Arterial Hypertension (PAH) agents **Adcirca® (g)** (alyq™, tadalafil), **Letairis® (g)** (ambrisentan), **Opsumit®** (macitentan), **Revatio® (g)** (sildenafil citrate), **Tracleer®** (bosentan)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for sildenafil and tadalafil in situations where patients are receiving nitrate therapy. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Qinlock™ (ripretinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ravicti® (glycerol phenylbutyrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Rebif® (interferon beta-1a)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Relistor® (methylnaltrexone)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage is not provided for patients with known or suspected mechanical gastrointestinal obstruction. **Age restriction:** Patients 18 years of age and older. **Coverage duration:** 3 months.
Repatha® (evolocumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Retevmo™ (selpercatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Revcovi™ (elapegademase-lvlr)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Revlimid® (lenalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** Must be prescribed by or in consultation with an oncologist or hematologist. **Coverage duration:** 1 year.
Rexulti® (brexpiprazole)	Coverage requires the trial of or intolerance to Abilify Maintena or oral aripiprazole. **Coverage duration:** Lifetime.
Risperdal Consta® (risperidone)	Coverage requires the trial of oral risperidone. **Coverage duration:** Lifetime.
Rozlytrek™ (entrectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Rubraca™ (rucaparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Ruzurgi® (amifampridine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Rydapt® (midostaurin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Samsca® (tolvaptan)	Coverage requires documentation that the member does not have underlying liver disease. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 month.
Sarclisa® (isatuximab-irfc)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Savella® (milnacipran)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Sirturo™ (bedaquiline fumarate)	Coverage is provided when used in combination with at least 3 other agents. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Somavert® (pegvisomant)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sovaldi® (sofosbuvir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.

MEDICATION/ DRUG CLASS	CRITERIA
Sprycel® (dasatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Stelara® (ustekinumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Sutent® (sunitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions**: Prescribing physician must be an oncologist. **Coverage duration:** 1 year.
Sylatron™ (peginterferon alfa-2b)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions**: Prescribing physician must be an oncologist. **Coverage duration:** 1 year.
Symlin® (pramlintide)	Coverage is provided for patients that have failed intensive treatment with insulin monotherapy and for concurrent use with an insulin product. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Tabloid® (thioguanine)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions**: Prescribing physician must be an oncologist or hematologist. **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Tabrecta™ (capmatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tafinlar® (dabrafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tagrisso™ (osimertinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Talzenna™ (talazoparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tarceva® (g) (erlotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** must be prescribed by an Oncologist. **Coverage duration:** 1 year.
Targretin® (bexarotene)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** must be prescribed by an Oncologist or Dermatologist. **Coverage duration:** 1 year.
Tasigna® (nilotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Tazverik™ (tazemetostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tecfidera™ (dimethyl fumarate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Tegsedi™ (inotersen)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration**: 1 year.
Thalomid® (thalidomide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tibsovo® (ivosidenib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Trikafta™ (elexacaftor/tezacaftor/ivacaftor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Trodelvy™ (sacituzumab govitecan-hziy)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Tukysa™ (tucatinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Turalio™ (pexidartinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Uloric® (febuxostat)	Coverage requires the trial of or contraindication to allopurinol. **Coverage duration:** Lifetime.
Uptravi® (selexipag)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vecamyl™ (mecamylamine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Venclexta™ (venetoclax)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Verzenio™ (abemaciclib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vitrakvi® (larotrectinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vizimpro® (dacomitinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Criteria will be applied consistent with current AASLD/IDSA guidance.
Votrient® (pazopanib)	*All medically accepted indications not otherwise excluded from Part D.* **Prescriber restrictions:** must be prescribed by an Oncologist. **Coverage duration:** 1 year.
Vyndamax™ (tafamidis)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Vyndaqel® (tafamidis meglumine)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xalkori® (crizotinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xcopri® (cenobamate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xeljanz®, **Xeljanz® XR** (tofacitnib citrate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Xenazine® (g) (tetrabenazine)	Coverage requires documentation of the patient's CYP2D6 genotype for doses above 50mg per day. *All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided in the following situations, 1) Patients with hepatic function impairment, 2) Patients who are actively suicidal or who have untreated or inadequately treated depression, 3) Patients taking monoamine oxidase inhibitors or reserpine. **Coverage duration:** 1 year.
Xgeva® (denosumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xolair® (omalizumab)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xospata® (gilteritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xpovio™ (selinexor)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Xtandi® (enzalutamide)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Xyrem® (sodium oxybate)	**Exclusion criteria:** Coverage is not provided for patients taking sedative hypnotics or in patients with succinic semialdehyde dehydrogenase deficiency. *All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Yonsa® (abiraterone acetate)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zejula™ (niraparib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Zelboraf® (vemurafenib)	*All medically accepted indications not otherwise excluded from Part D.* **Exclusion criteria:** Coverage will not be provided in combination with Yervoy®. **Coverage duration:** 1 year.
Zenpep® (pancrelipase delayed release)	Coverage requires the trial of or intolerance to Creon®. **Coverage duration:** Lifetime.
Zepzelca™ (lurbinectedin)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zolinza® (vorinostat)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.

MEDICATION/ DRUG CLASS	CRITERIA
Zydelig™ (idelalisib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.
Zykadia™ (ceritinib)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** Lifetime.
Zytiga® (abiraterone)	*All medically accepted indications not otherwise excluded from Part D.* **Coverage duration:** 1 year.