Blue Care Network
Prior Approval and Step Therapy Guidelines
May 2018

Blue Care Network's Prior Approval and Step Therapy Guidelines help ensure that safe, high-quality cost-effective drugs are prescribed prior to the use of more expensive agents that may not have proven value over current preferred medications. Our prior approval and step therapy criteria are based on current medical information and have been approved by the Blue Cross and BCN Pharmacy and Therapeutics Committee. These guidelines apply to all BCN members with a commercial benefit.

PRIOR APPROVAL (PA): Drugs requiring PA are covered only if the member meets specific criteria.
STEP THERAPY (ST): Drugs subject to ST require previous treatment with one or more preferred agents prior to coverage.

Note:

- BCN members with a two-tier closed drug plan do not have coverage for tier 3 (nonpreferred) drugs. Requests for coverage of nonpreferred drugs are considered when the member meets BCN's criteria and the member has tried and failed to respond to an adequate trial of the available preferred agents, or the available preferred agents would pose unnecessary risk to the member.

Please visit us online at bcbsm.com/pharmacy for more information.

This information applies to members with a BCN commercial drug benefit. Criteria for **BCN Advantage**SM members can be viewed on our Web site: bcbsm.com.

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Absorica	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to generic isotretinoin (such as Claravis (isotretinoin)).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Abstral	Coverage is provided for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and who are currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of Actiq (fentanyl citrate) and other oral immediate-release narcotics (such as MSIR (morphine sulfate immediate-release) or oxycodone immediate-release) for the management of breakthrough pain.	PA	PA	Not Covered
Aciphex Sprinkle	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to three generic proton pump inhibitors (such as Prilosec (omeprazole)).	ST	Not Covered	Not Covered
Actemra	Coverage is provided for members 18 years of age or older for the treatment of rheumatoid arthritis or giant cell artiritis.	PA	PA	PA
Acthar H.P.	Coverage is provided for the treatment of infantile spasms (West Syndrome).	PA	PA	Not Covered
Actiq (fentanyl citrate)	Coverage is provided for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and are currently receiving a long-acting narcotic (such as MS Contin (morphine sulfate)). The member must also have experienced treatment failure of or intolerance to the use of other oral immediate-release narcotics (such as MSIR (morphine sulfate immediate-release) or oxycodone immediate-release) for the management of breakthrough pain.	PA	PA	PA
Adcirca	Coverage requires documentation to support the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1). 2. Treatment failure or intolerance to generic Revatio.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Adderall XR (dextroamphetamine /amphetamine	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to brand name Adderall XR.	PA	PA	N/A
Addyi	Coverage is provided for the treatment of acquired, generalized hypoactive sexual desire disorder (HSDD) ongoing for a duration of at least 6 months in premenopausal females. Other causes (such as relationship difficulties or medication side effects) must be ruled out.	PA	PA	Not Covered
Adempas	Coverage requires documentation to support the following: 1. Diagnosis of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO GROUP 4) after surgical treatment or inoperable CTEPH. OR 2. Diagnosis of Pulmonary Arterial Hypertension (PAH)(WHO Group 1)	PA	PA	PA
Adoxa capsule (doxycycline monohydrate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Monodox (doxycycline monohydrate).	PA	PA	Not Covered
Adlyxin	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or BudureonBCise, Trulicity and Victoza.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Adzenys ER	Coverage is provided for members 6 years of age or older for the treatment of attention deficit hyperactivity disorder (ADHD) in situations where the member has experienced treatment failure of or intolerance to both a methylphenidate product (such as Concerta (methylphenidate) or Ritalin (methylphenidate)) AND an amphetamine product (such as Adderall (dextroamphetamine/amphetamine)), one of which must be a generic long acting formulation OR the physician provides documentation the member cannot swallow tablets/capsules and has experienced treatment failure of or intolerance to one of the agents that can be opened and sprinkled on applesauce (such as Adderall XR or Metadate CD (methylphenidate)).	PA	PA	PA
Adzenys XR-ODT	Coverage is provided for members 6 years of age or older for the treatment of attention deficit hyperactivity disorder (ADHD) in situations where the member has experienced treatment failure of or intolerance to both a methylphenidate product (such as Concerta (methylphenidate) or Ritalin (methylphenidate)) AND an amphetamine product (such as Adderall (dextroamphetamine/amphetamine)), one of which must be a generic long acting formulation OR the physician provides documentation the member cannot swallow tablets/capsules and has experienced treatment failure of or intolerance to one of the agents that can be opened and sprinkled on applesauce (such as Adderall XR or Metadate CD (methylphenidate)).	PA	PA	Not Covered
Afinitor, Disperz*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Afrezza	Coverage is provided for the treatment of diabetes mellitus in members who have experienced treatment failure of or intolerance to at least 3 months of therapy with subcutaneous rapid-acting insulin (such as Novolog) and a credible explanation as to why Afrezza is expected to work when the subcutaneous product has not must be submitted to the plan.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Akynzeo	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) Initial approval 1 year Renewal requires documentation of continuation of chemotherapy	PA	PA	PA
Alecensa*	Coverage requires documentation to support the following: 1. Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer Initial approval: 1 year Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity	PA	PA	PA
Alogliptin	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to the use of both preferred DPP-4 inhibitors (Januvia and Onglyza) AND at least one agent from THREE of the following drug classes: Glucophage (metformin), basal insulin, a sulfonylurea (such as Glucotrol (glipizide)), and a thiazolidinedione (such as Actos (pioglitazone)).	ST	ST	Not Covered
Alogliptin-metformin	Coverage is provided in situations where the member has experienced successful treatment for at least three months with the individual agents used in combination. Additional coverage criteria may apply to the individual agents.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Alogliptin-pioglitazone	Coverage is provided in situations where the member has experienced successful treatment for at least three months with the individual agents used in combination. Additional coverage criteria may apply to the individual agents.	ST	ST	Not Covered
Alunbrig*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Ampyra	**Initial treatment:** Coverage is provided for the treatment of multiple sclerosis in situations where the member experiences difficulty walking resulting in significant limitations of instrumental activities of daily living and when two timed 25-foot walk (T25FW) measurements that are within 10% variability and demonstrates that the member is able to walk 25 feet in 8-45 seconds are submitted to the plan, and where the member is on current disease-modifying therapy. **To continue:** Coverage is provided in situations where the member's walking speed has improved by at least 20% as assessed by the T25FW AND that limitations of instrumental activities of daily living have improved as a result of increased walking speed within the first 2 months of therapy. Coverage thereafter will be provided if there is documentation that the member has maintained or experienced improved walking speed from the previous measurement, and where the member is on current disease-modifying therapy.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Androderm	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	PA	PA	PA
Androgel 1% (testosterone)	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	PA	PA	PA

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Androgel 1.62%	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	PA	PA	PA
Apidra, Solostar	Coverage is provided in situations where the member has failed to achieve glycemic control with use of Novolin or Novolog for at least three months.	ST	ST	Not Covered
Aplenzin	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three generic antidepressants, one of which is Wellbutrin SR/XL (bupropion).	PA	PA	PA
Aptiom	Coverage requires documentation to support the following: 1. Treatment of seizures in patients with epilepsy 2. Has experienced treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures OR Currently stable on Aptiom for the treatment of seizures.	PA	PA	Not Covered

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Aranesp	Coverage is provided for the treatment of FDA approved indications in situations where the member has experienced treatment failure of or intolerance to Procrit.	PA	PA	PA
Arcalyst*	Coverage is provided for the treatment of cryopyrin-associated periodic syndrome in members 12 years of age or older.	PA	PA	PA
Arimidex* (anastrozole)	PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.	PA	PA	PA
Aromasin* (exemestane)	PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.	PA	PA	PA
Atelvia (risedronate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two of the following preferred alternatives: Actonel (risedronate), Boniva (ibandronate), or Fosamax (alendronate).	ST	ST	ST
Austedo	Coverage requires documentation to support the following: 1.Diagnosis of chorea associated with Huntington's disease OR 2.Diagnosis of Tardive Dyskinesia	PA	PA	PA

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Axiron (testosterone)	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered
Beconase AQ	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Flonase (fluticasone propionate) or Nasalide (flunisolide)/Nasarel (flunisolide) AND Nasacort AQ (triamcinolone acetonide).	ST	Not Covered	Not Covered
Belbuca	Coverage is provided for the treatment of moderate to severe chronic pain in situations where the member has experienced treatment failure of or intolerance to at least TWO of the following: Duragesic (fentanyl), methadone, MS Contin (morphine sulfate extended release)**,** Ultram ER (tramadol extended release), Butrans patch (buprenorphine).	PA	PA	Not Covered
Belsomra	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to three of the following: Ambien (zolpidem), Desyrel (trazodone), Lunesta (eszopiclone), or Sonata (zaleplon).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Belviq, XR	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia. Maximum benefit is limited to 12 months of treatment.	PA	PA	Not Covered
Benlysta	Coverage is provided for members 18 years of age or older for the treatment of systemic lupus erythematosus (SLE) and whose diagnosis had been confirmed by a positive test for serum antibodies (examples: ANA, anti-dsDNA) at 2 independent time points and a Score on the Safety of Estrogens in Lupus Erythematosus National Assessment modification on the SLE Disease Activity Index (SELENA-SLEDAI, a disease activity score) of at least 6. Member must not have kidney inflammation as well as lupus affecting the brain or spine and has failed 2 or more of the following: hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide OR mycophenolate mofetil for 12 weeks unless all are contraindicated. Member must continue to receive a stable standard of care regimen.	PA	PA	PA
Bethkis	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in cystic fibrosis in situations where the member has experienced treatment failure of or intolerance to generic inhaled tobramycin (such as Tobi (tobramycin in 0.225% sodium chloride)) and a credible explanation as to why the requested product is expected to work when the generic product has not has been submitted to the plan.	PA	PA	Not Covered
Binosto	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two of the following preferred alternatives: Actonel (risedronate), Boniva (ibandronate), or Fosamax (alendronate).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Bonjesta	Coverage requires documentation to support the following: 1. Treatment of nausea and vomiting of pregnancy 2. Trial and treatment failure of the individual agents (doxylamine and pyridoxine) in combination.	PA	PA	Not Covered
Bosulif*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Bravelle	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	Not Covered
Brisdelle (paroxetine mesylate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Effexor (venlafaxine) and Paxil (paroxetine hcl).	PA	PA	Not Covered
Briviact	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives, one of which must be generic Keppra OR Currently stable on Briviact for the treatment of seizures.	PA	PA	PA

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Bystolic	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least two preferred cardioselective beta blockers, such as Kerlone (betaxolol), Sectral (acebutolol), Tenormin (atenolol), Toprol XL (metoprolol), or Zebeta (bisoprolol).	ST	ST	ST
Cabometyx*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Calquence*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Caprelsa*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Carbaglu	Coverage is provided for the treatment of hyperammonemia due to a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) as confirmed by enzyme or DNA mutation analysis.	PA	PA	PA
Cayston	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in members with cystic fibrosis.	PA	PA	PA
Cerdelga	Treatment of adult patients with Gaucher disease type 1 who are cytochrome P450 (CYP-450) 2D6 extensive metabolizers, intermediate metabolizers or poor metabolizers. Renewal Criteria: Provide documentation of stability or improvement in disease (this may include, but is not limited to, hematologic indices, and/or MRI of spine/femurs).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Cetrotide	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	Not Covered
Chenodal	Coverage is provided for the treatment of cholelithiasis (gallstones) in members ineligible for surgery who have experienced treatment failure of or intolerance to Actigall (ursodiol).	PA	PA	PA
Cholbam	Coverage is provided for the treatment of bile acid synthesis disorders due to single enzyme defects (SEDs) or peroxisomal disorders (PDs) (including Zellweger spectrum disorders) with manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.	PA	PA	PA
Chorionic Gonadotropin	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	PA
Cialis	Coverage is provided for male members for the treatment of erectile dysfunction in situations where the member has experienced treatment failure of or intolerance to Revatio (sildenafil). Maximum of 6 doses per 28 days.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Cialis 2.5 mg, 5 mg	Coverage is provided for the treatment of benign prostatic hyperplasia (BPH) in situations where the member has experienced treatment failure of or intolerance to an alpha blocker (such as Cardura (doxazosin)) AND a 5-alpha reductase inhibitor (such as Proscar (finasteride)).	PA	PA	Not Covered
Cimzia syringe	Coverage is provided for members 18 years of age or older for the treatment of: • **Ankylosing spondylitis** in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Cosentyx, Enbrel, or Humira. • **Crohn's disease** in situations where the member has experienced treatment failure of or intolerance to an adequate course of systemic corticosteroids or immunomodulatory medication for at least 2 months and Humira. • **Moderate to severe rheumatoid arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of one nonbiologic disease modifying anti-rheumatic drug (DMARD) and TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR. • **Psoriatic arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of one nonbiologic disease modifying anti-rheumatic drug (DMARD) and TWO of the following: Cosentyx, Enbrel, Humira, or Stelara.	PA	PA	PA
Cometriq*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

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Compounds	Coverage criteria include all the below: • The compound is medically necessary for the member's condition. • The compound contains only FDA approved medications. • There are no appropriate FDA approved commercial formulations of the compound available. **Note**: U6Ws (bulk powders) are not covered.	PA	PA	Not Covered
Contrave ER	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia. Maximum benefit is limited to 12 months of treatment.	PA	PA	Not Covered
Coreg CR (carvedilol ER)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to both Coreg (carvedilol) AND Toprol XL (metoprolol).	ST	ST	Not Covered
Corlanor	Coverage is provided for members with heart failure and a left ventricular ejection fraction ≤ 35% in situations where the member is currently stable on a maximally tolerated dose of a beta-blocker (such as Toprol XL (metoprolol)) or has a documented contraindication to beta-blocker use. Coverage is not provided for use in combination with Entresto.	PA	PA	PA
Cosentyx	Coverage is provided for members 18 years of age or older for the treatment of ankylosing spondylitis, moderate to severe plaque psoriasis, and psoriatic arthritis.	PA	PA	PA
Cotellic*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

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Crinone 8%	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	Not Covered
Cuvitru	Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met.	PA	PA	Not Covered
Cycloset	Coverage is provided in members who have experienced treatment failure or intolerance to at least 2 generic oral diabetes drugs.	ST	ST	ST
Cystaran	Coverage is provided for members with a diagnosis of cystinosis who are also taking oral cysteamine (such as Cystagon).	PA	PA	PA
Daklinza	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Members taking Daklinza must be receiving combination therapy with Sovaldi. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to Zepatier or Epclusa.	PA	PA	PA
Daliresp	Coverage is provided for the treatment of severe chronic obstructive pulmonary disorder (COPD) associated with chronic bronchitis and a history of exacerbations despite optimal therapy with a long acting beta agonist (such as Serevent), an inhaled anticholinergic (such as Spiriva), and a generic inhaled corticosteroid (such as Qvar).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Daraprim	Coverage is provided for malaria chemoprophylaxis and the treatment of malaria or toxoplasmosis.	PA	PA	PA
Desvenlafaxine ER	Requires trial and failure of at least three generic or preferred antidepressant agents.	PA	PA	Not Covered
Dexilant	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to all of the following: Aciphex (rabeprazole), Prevacid (lansoprazole), Prilosec (omeprazole) or Prilosec OTC, AND Protonix (pantoprazole), one of which is at a twice daily, high dose regimen.	ST	Not Covered	Not Covered
Dibenzyline (phenoxybenzamine hcl)	Coverage is provided for the treatment of hypertension and sweating episodes due to pheochromocytoma: **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 duration: up to 14 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)).	PA	PA	PA
Diclegis	Coverage is provided when the member has experienced treatment failure to the use of the individual agents (doxylamine and pyridoxine) in combination.	PA	PA	Not Covered
Doryx (doxycycline hyclate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Doxycycline 20 mg (doxycycline hyclate) or Vibramycin (doxycycline hyclate).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Doryx MPC	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Doxycycline 20 mg (doxycycline hyclate) or Vibramycin (doxycycline hyclate).	PA	PA	Not Covered
Doxycycline IR-DR	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Monodox (doxycycline monohydrate).	PA	PA	Not Covered
Duopa	Coverage is provided for the treatment of advanced Parkinson's disease for members with a feeding tube.	PA	PA	PA
Dupixent	Coverage is provided for the treatment of atopic dermatitis for members 18 years of age or older in situations where the prescription is written by a dermatologist or an allergist and the member has experienced treatment failure of or intolerance to all of the following: phototherapy or photochemotherapy (PUVA), two topical steroid creams, one of which is medium or high potency (such as Diprosone (betamethasone) or Elocon (mometasone)), a topical calcineurin inhibitor (such as Protopic (tacrolimus)), and an oral systemic agent (such as methotrexate).	PA	PA	PA
Duzallo	Coverage is provided for the treatment of gout in situations where the member has a uric acid level greater than 6 mg/dL and has experienced treatment failure of or intolerance to Zyloprim (allopurinol).	PA	PA	Not Covered
Dyanavel XR	Coverage is provided for members 6 years of age or older for the treatment of attention deficit hyperactivity disorder (ADHD) in situations where the member has experienced treatment failure of or intolerance to both a methylphenidate product (such as Concerta (methylphenidate) or Ritalin (methylphenidate)) AND an amphetamine product (such as Adderall (dextroamphetamine /amphetamine)), one of which must be a generic long acting formulation OR the physician provides documentation the member cannot swallow tablets/capsules and has experienced treatment failure of or intolerance to one of the agents that can be opened and sprinkled on applesauce (such as Adderall XR or Metadate CD (methylphenidate)).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Dymista	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic nasal steroids (such as Flonase (fluticasone propionate) and Nasacort AQ (triamcinolone acetonide)) AND has experienced successful treatment with the individual agents in combination (Astelin (azelastine) and Flonase (fluticasone propionate)) for at least three months.	PA	Not Covered	Not Covered
Edarbi	Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB).	ST	ST	ST
Edarbyclor	Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB).	ST	ST	ST
Edluar	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Ambien CR (zolpidem) and either Lunesta (eszopiclone) or Sonata (zaleplon).	ST	ST	Not Covered
Egrifta	Coverage is provided for members 18 years of age or older for the treatment of excess abdominal fat in HIV-associated lipodystrophy who are receiving antiretroviral therapy.	PA	PA	Not Covered
Embeda	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate), methadone, Butrans (buprenorphine), Ultram ER (tramadol), OR Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA

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Emflaza	Coverage is provided for members 5 years of age or older for the treatment of Duchenne's Muscular Dystrophy in situations where the member has experienced treatment failure of or intolerance to prednisone or prednisolone.	PA	PA	PA
Enbrel	Coverage is provided for the treatment of ankylosing spondylitis, pediatric psoriasis, polyarticular juvenile idiopathic arthritis, psoriatic arthritis, and rheumatoid arthritis. Coverage is provided for the treatment of moderate to severe plaque psoriasis in situations where the member has experienced treatment failure of or intolerance to Humira.	PA	PA	PA
Endari	Coverage is provided for members 5 years of age or older for the treatment of sickle cell disease in situations where the member has experienced treatment failure of or intolerance to Hydrea (hydroxyurea).	PA	PA	PA
Endometrin	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	Not Covered
Enstilar	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least 30 days of treatment with the combination of a very high potency corticosteroid (such as: Diprolene ointment (betamethasone), Psorcon (diflorasone), Temovate (clobetasol)) plus Dovonex (calcipotriene) AND Taclonex (calcipotriene/betamethasone) ointment.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Epclusa	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C for genotypes 1,2, 3,4, 5 and 6 with a fibrosis staging score greater than or equal to F2 who meet clinical criteria. Coverage is reviewed on a case by case basis using the AASLD guidelines and FDA approved package labelling.	PA	PA	PA
Epogen	Coverage is provided for the treatment of FDA approved indications in situations where the member has experienced treatment failure of or intolerance to Procrit.	PA	PA	PA
Erivedge*	Coverage is provided for the treatment of the FDA approved indications	PA	PA	PA
Esbriet	Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF).	PA	PA	PA
Eucrisa	Coverage is provided for the treatment of atopic dermatitis in members 2 years of age or older in situations where the member has experienced treatment failure of or intolerance to two topical steroids, one of which is medium or high potency (such as Diprosone (betamethasone) or Elocon (mometasone)) and a topical calcineurin inhibitor (such as Protopic (tacrolimus)).	PA	PA	Not Covered
Evista* (raloxifene)	Female members qualify for a $0 copayment when the following clinical criteria are met: Coverage is provided for primary prevention of breast cancer in women age 35 years or older with documented risk factors showing the member is at high risk for developing breast cancer and the member has no history of breast cancer, ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS), or a personal/family history of venous thromboembolic events.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Exalgo (hydromorphone hcl))	Coverage requires documentation to support 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 of the following: a. Generic extended release morphine (Kadian, MS Contin) b. Generic fentanyl transdermal patch (Duragesic) c. Generic extended release tramadol (Ultram ER) d. Methadone e. Generic buprenorphine transdermal patch (Butrans). Authorization: 1 year Renewal requires documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective. **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA
Exjade	Coverage is provided for members 2 years of age or older for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) or transfusional iron overload due to thalassemia syndromes in situations where the member has experienced treatment failure of or intolerance to Desferal (deferoxamine).	PA	PA	PA
Fanapt	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic 2nd generation antipsychotics (such as Abilify (aripiprazole) or Seroquel (quetiapine)).	ST	ST	ST
Farydak*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Fazaclo (clozapine)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Clozaril (clozapine) tablets, unless the member is unable to swallow tablets/capsules.	ST	ST	ST
Fazaclo 150, 200 mg	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Clozaril (clozapine) tablets, unless the member is unable to swallow tablets/capsules.	ST	ST	ST
Femara* (letrozole)	PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.	PA	PA	PA
Fentora	Coverage is provided for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and who are currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of Actiq (fentanyl) and other oral immediate-release narcotics for the management of breakthrough pain.	PA	PA	Not Covered
Ferriprox	Coverage is provided for the treatment of transfusional iron overload due to thalassemia syndromes in situations where the member has experienced treatment failure of or intolerance to Desferal (deferoxamine) and Exjade. Additional coverage criteria applies to Exjade.	PA	PA	PA
Fetzima	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least two generic selective serotonin reuptake inhibitors (such as Prozac (fluoxetine) or Zoloft (sertraline)) AND one generic serotonin-norepinephrine reuptake inhibitor (such as Effexor (venlafaxine)).	PA	PA	Not Covered
Fioricet 50/300/40 mg (butalbital/acetaminophen/caffeine)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to a similar product containing 325 mg of acetaminophen (such as Esgic (butalbital/acetaminophen/caffeine)).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Fioricet w/codeine 50/300/30 mg (butalbital/acetaminophen/caffeine/codeine)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to a similar product containing 325 mg of acetaminophen (such as Esgic (butalbital/acetaminophen/caffeine)).	PA	PA	PA
Firazyr	Coverage is provided for members 18 years of age or older with a confirmed diagnosis of type 1 or type 2 hereditary angioedema (HAE) for the treatment of acute attacks or short-term prophylaxis in members who have experienced treatment failure of or intolerance to an attenuated androgen (such as Danocrine (danazol) or Oxandrin (oxandrolone)).	PA	PA	PA
Flector Patch	Coverage is provided for the treatment of acute sprains, strains and contusions in situations where the member has experienced treatment failure of or intolerance to an OTC topical analgesic (Aspercreme OR Myoflex) and Voltaren/XR (diclofenac sodium) tablets.	PA	PA	Not Covered
Follistim AQ	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice. Coverage also requires treatment failure of or intolerance to Gonal-F, -RFF, Redi-ject.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Forteo	Coverage is provided for the treatment of osteoporosis in situations where the member has a contraindication to or has experienced treatment failure of or intolerance to a preferred bisphosphonate (such as Actonel (risedronate))**.**	PA	PA	PA
Fortesta, Testosterone (Brand) 2% pump	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered
Fosamax Plus D	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two of the following preferred alternatives: Actonel (risedronate), Boniva (ibandronate), or Fosamax (alendronate).	ST	ST	Not Covered
Frova (frovatriptan succinate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic triptans (such as Imitrex (sumatriptan) or Maxalt (rizatriptan)).	ST	ST	ST

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Gammagard liquid	Coverage is provided for treatment of the following indications when clinical criteria is met: acquired factor VIII inhibitor, allogeneic bone marrow transplant, autoimmune hemolytic anemia (AIHA), dermatomyositis, fetal alloimmunethrombocytopenia, HIV Infection, hypogammaglobulinemia, inflammatory demyelinating polyneuropathy, idiopathic thrombocytopenia purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, multifocal motor neuropathy, multiple myeloma, myasthenia gravis, pediatric intractable epilepsy, polymyositis, post-transfusion purpura, primary humoral immunodeficiency, pure red cell aplasia, refractory pemphigus foliaceus, solid organ transplant, stiff person syndrome, systemic lupus erythematosus.	PA	PA	PA
Gammaked liquid	Coverage is provided for treatment of the following indications when clinical criteria is met: acquired factor VIII inhibitor, allogeneic bone marrow transplant, autoimmune hemolytic anemia (AIHA), dermatomyositis, fetal alloimmunethrombocytopenia, HIV Infection, hypogammaglobulinemia, inflammatory demyelinating polyneuropathy, idiopathic thrombocytopenia purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, multifocal motor neuropathy, multiple myeloma, myasthenia gravis, pediatric intractable epilepsy, polymyositis, post-transfusion purpura, primary humoral immunodeficiency, pure red cell aplasia, refractory pemphigus foliaceus, solid organ transplant, stiff person syndrome, systemic lupus erythematosus.	PA	PA	PA
Gamunex-C sub-q	Coverage is provided for treatment of the following indications when clinical criteria is met: acquired factor VIII inhibitor, allogeneic bone marrow transplant, autoimmune hemolytic anemia (AIHA), dermatomyositis, fetal alloimmunethrombocytopenia, HIV Infection, hypogammaglobulinemia, inflammatory demyelinating polyneuropathy, idiopathic thrombocytopenia purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, multifocal motor neuropathy, multiple myeloma, myasthenia gravis, pediatric intractable epilepsy, polymyositis, post-transfusion purpura, primary humoral immunodeficiency, pure red cell aplasia, refractory pemphigus foliaceus, solid organ transplant, stiff person syndrome, systemic lupus erythematosus.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Ganirelix Acetate	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	Not Covered
Gattex	Coverage is provided for members 18 years of age or older with a diagnosis of Short Bowel Syndrome (SBS) AND dependence on parenteral support $\geq$ 12 months.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Genotropin	**Children (< 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA
Gilotrif*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Glassia	Coverage is provided for the treatment of emphysema associated with alpha-1 antitrypsin deficiency in situations where all of the following criteria is met: 1) the member is a nonsmoker, 2) the member has evidence of deteriorating pulmonary function (as demonstrated by an FEV1 between 35% and 60% predicted), and 3) the member has a baseline plasma alpha-1 antitrypsin level less than 80 mg/dL consistent with phenotypes PiZZ, PiZ (null), or Pi (null, null).	PA	PA	PA
Glyxambi	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of 3 of the following preferred SGLT-2 inhibitors (Farxiga or Xigduo, Invokana or Invokamet, Jardiance or Synjardy/Synjardy XR).	PA	PA	Not Covered
Gonal-F, RFF, Redi-ject	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	PA
Gralise	Coverage is provided for the treatment of neuropathic pain associated with post-herpetic neuralgia in situations where the member has experienced treatment failure of or intolerance to Neurontin (gabapentin). Members 65 years of age or younger must also experience treatment failure of or intolerance to a tricyclic antidepressant (such as Elavil (amitriptyline)). A credible explanation as to why Gralise is expected to work if Neurontin (gabapentin) did not must be submitted to the plan.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Grastek	Coverage is provided for the treatment of allergic rhinitis with or without conjunctivitis with confirmed sensitivity to at least one allergen contained in the requested agent in members who have experienced treatment failure of or intolerance to all of the following drug classes: an intranasal corticosteroid (such as Flonase (fluticasone propionate)), an antihistamine (such as Zyrtec (cetirizine)) and a leukotriene inhibitor (such as Singulair (montelukast)).	PA	PA	Not Covered
Haegarda	Coverage is provided for diagnosis of type 1 or type 2 hereditary angioedema (HAE) in adolescent and adult patients for long term prophylaxis and whose diagnosis has been confirmed by genetic testing or when laboratory finding meet clinical criteria. Member must also have a history of severe HAE attacks or having at least 2 HAE attacks a month and had an Inadequate response or intolerance to attenuated androgens (i.e., danazol, stanozol, and oxandrolone).	PA	PA	PA
Harvoni	Coverage is provided for members 12 years of age or older for the treatment of chronic hepatitis C with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to Zepatier or Epclusa.	PA	PA	PA
Hetlioz	Coverage is provided for the treatment of Non-24-Hour Sleep-Wake Disorder in completely blind members 18 years of age or older in situations where the member has experienced treatment failure of or intolerance to both an OTC melatonin and Rozerem®.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Hizentra	Coverage is provided for treatment of the following indications when clinical criteria is met: acquired factor VIII inhibitor, allogeneic bone marrow transplant, autoimmune hemolytic anemia (AIHA), dermatomyositis, fetal alloimmunethrombocytopenia, HIV Infection, hypogammaglobulinemia, inflammatory demyelinating polyneuropathy, idiopathic thrombocytopenia purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, multifocal motor neuropathy, multiple myeloma, myasthenia gravis, pediatric intractable epilepsy, polymyositis, post-transfusion purpura, primary humoral immunodeficiency, pure red cell aplasia, refractory pemphigus foliaceus, solid organ transplant, stiff person syndrome, systemic lupus erythematosus.	PA	PA	PA
Horizant	**Restless Legs Syndrome (RLS):** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Mirapex (pramipexole), Neurontin (gabapentin), and Requip/XL (ropinirole), and a credible explanation as to why Horizant is expected to work if Neurontin (gabapentin) did not must be submitted to the plan. **Post-herpetic neuralgia:** Coverage is provided for members 65 years of age or older who have experienced treatment failure of or intolerance to Neurontin (gabapentin). Members less than 65 years of age also require treatment failure of or intolerance to a tricyclic antidepressant (such as Elavil (amitriptyline)).	PA	PA	Not Covered
Humalog, Mix (except U-200)	Coverage is provided in situations where the member has failed to achieve glycemic control with use of Novolin or Novolog for at least three months.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Humira	Coverage requires documentation of the following: **1. <u>Rheumatoid arthritis, juvenile idiopathic arthritis or psoriatic arthritis</u>:** Requires three-month trial with one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine). **2. <u>Ankylosing spondylitis</u>** **3. <u>Moderate to severe psoriasis</u>:** Requires 3 months of previous treatment with topical corticosteroids and 3 months treatment with phototherapy or photo chemotherapy (unless contraindicated) and therapy must be supervised by a Dermatologist. **4. <u>Crohn's Disease</u>:** Coverage for patients age 6 years and older with a diagnosis of moderately to severely active Crohn's disease with a history of inadequate response to conventional therapy. **5. <u>Ulcerative Colitis</u>:** Coverage for patients age 18 years and older with a diagnosis of moderately to severely active Ulcerative Colitis with a history of inadequate response to conventional therapy **6. <u>Hiradenitis suppurativa:</u>** Coverage for patients 18 years and older, prescribed by or in consultation with a dermatologist and requires a 3 month trial of oral antibiotics **7. <u>Uveitis:</u>** a. ≥ 18 years old b. Diagnosis of non-infectious intermediate uveitis, posterior uveitis or panuveitis. c. Prescribed by ophthalmologist or rheumatologist d. Trial of an oral corticosteroid e. Trial of an oral immunomodulatory agent. Examples include: methotrexate, azathioprine, cyclosporine.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Humulin, Kwikpen (except U-500)	Coverage is provided in situations where the member has failed to achieve glycemic control with use of Novolin or Novolog for at least three months.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Humatrope	**Children (< 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note**: Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
HyQvia	Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met.	PA	PA	PA
Hysingla ER	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate), methadone, Butrans (buprenorphine), Ultram ER (tramadol), OR Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	Not Covered
Ibrance*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Iclusig*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Idhifa*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Imbruvica*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Increlex	Coverage is provided for the treatment of severe IGF-1 deficiency, growth hormone gene deletion, and Laron's syndrome in members less than 18 years of age with open epiphyses and height below the 3rd percentile. The member must have a normal or elevated growth hormone level with an IGF-1 level 3 or more standard deviations below normal. • **To Continue:** Renewal can be obtained if the member has clinical response with therapy, as demonstrated by an annual growth velocity of ≥ 2.5 cm. **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Ingrezza	Coverage is provided for members 18 years of age or older for the treatment of tardative dyskinesia when prescribed by a psychiatrist or neurologist.	PA	PA	PA
Inlyta*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Intermezzo (zolpidem tartrate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Ambien CR (zolpidem) and either Lunesta (eszopiclone) or Sonata (zaleplon).	PA	PA	Not Covered
Iressa*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Jadenu/Jadenu Sprinkle	**Initial treatment:** Coverage is provided for the treatment of chronic iron overload due to blood transfusions and non-transfusion dependent thalassemia (NTDT) syndromes in situations where the member has experienced treatment failure of or intolerance to Desferal (deferoxamine) and when the member's baseline ferritin level has been submitted to the plan. **To continue:** Coverage will continue to be provided when the member has shown improvement in their ferritin level from baseline. The member's current ferritin level while on therapy must be submitted to the plan.	PA	PA	Not Covered
Jakafi*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Jentadueto	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	Not Covered
Jentadueto XR	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Juxtapid	Coverage is provided for the treatment of homozygous familial hypercholesterolemia (HoFH) in situations where the member is receiving optimal adjunctive treatment with a statin (such as Zocor (simvastatin)), a low-fat diet and other oral lipid lowering treatments; and has experienced treatment failure of or intolerance to Kynamro.	PA	PA	Not Covered
Kalydeco	Coverage is provided for the treatment of FDA approved indications when genetic testing has been submitted to the plan to document the appropriate gene mutation.	PA	PA	PA
Kazano	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	Not Covered
Keveyis	Coverage is provided for the treatment of hyperkalemic or hypokalemic periodic paralysis as confirmed by genetic testing or positive family history in members who have experienced treatment failure of lifestyle modifications (such as dietary and exercise alterations) AND Diamox (acetazolamide).	PA	PA	PA
Kevzara	Coverage is provided for the treatment of rheumatoid arthritis when the prescription is written by a rheumatologist in situations where the member has experienced treatment failure of or intolerance to one disease modifying anti-rheumatic drug (DMARD), such as methotrexate, and at least TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR.	PA	PA	PA
Khedezla	Requires trial and failure of at least three generic or preferred antidepressant agents.	PA	PA	Not Covered
Kineret	Coverage is provided for members 18 years of age or older for the treatment of rheumatoid arthritis in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Kisqali, Kisqali-Femara co-pack*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Korlym	Coverage is provided for members 18 years of age or older with Cushing's syndrome for the treatment of the following: • **Diabetes mellitus:** in situations where the member has experienced treatment failure of or intolerance to ALL of the following: surgery or radiotherapy, at least 3 months of insulin therapy, and a steroidogenesis inhibitor (such as Nizoral (ketoconazole)). A hemoglobin A1c level within the past year must also be submitted. • **Glucose intolerance:** Coverage is provided secondary to hypercortisolism in situations where the member has experienced treatment failure of or intolerance to surgery or radiotherapy AND a steroidogenesis inhibitor (such as Nizoral (ketoconazole)). A 2-h oral glucose tolerance test (OGTT) within the past year must also be submitted. Initial approval duration: up to 6 months. The member must demonstrate clinically significant improvement in glucose control for continuation of therapy.	PA	PA	PA
Kuvan	Coverage is provided for the treatment of phenylketonuria (PKU) in members following a phenylalanine-restricted diet in conjunction with Kuvan use.	PA	PA	PA
Kynamro	Coverage is provided for the treatment of homozygous familial hypercholesterolemia (HoFH) in situations where the member is receiving optimal adjunctive treatment with a statin (such as Zocor (simvastatin)), a low-fat diet, and other oral lipid lowering treatments.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Latuda	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic 2nd generation antipsychotics (such as Abilify (aripiprazole) or Seroquel (quetiapine)).	ST	ST	ST
Lazanda	Coverage is provided for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and who are currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of Actiq (fentanyl) and other oral immediate-release narcotics for the management of breakthrough pain.	PA	PA	Not Covered
Lenvima*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Letairis	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Levitra	Coverage is provided for male members for the treatment of erectile dysfunction in situations where the member has experienced treatment failure of or intolerance to Revatio (sildenafil). Maximum of 6 doses per 28 days.	PA	PA	Not Covered
Livalo	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic statins, <u>one</u> of which must be high dose (<u>≥</u> 40 mg) Lipitor (atorvastatin).	ST	ST	ST
Lonsurf*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Lovaza (omega-3 acid ethyl esters)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to all of the following: Lopid (gemfibrozil), an over-the-counter (OTC) omega-3 fatty acid at a dose of at least 3 grams/day, and a generic fenofibrate (such as Antara (fenofibrate, micronized), Lofibra (fenofibrate), or Tricor (fenofibrate nanocrystallized)). Also requires triglyceride levels ≥ 500 mg/dl.	PA	PA	PA
Lynparza*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Lyrica	**Seizure disorder:** Coverage is provided in situations where the member is being treated concurrently with other anticonvulsants. **Neuropathic pain:** Coverage is provided for treatment of diabetic peripheral neuropathy, post-herpetic neuralgia or neuropathy associated with spinal cord injury in situations where the member has experienced treatment failure of or intolerance to Neurontin (gabapentin). Members younger than 65 years of age must also experience treatment failure of or intolerance to a tricyclic antidepressant (such as Elavil (amitriptyline)). **Fibromyalgia:** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Neurontin (gabapentin) AND at least three of the following: a tricyclic antidepressant (such as Elavil (amitriptyline)), a selective serotonin reuptake inhibitor (SSRI) (such as Zoloft (sertraline)), a serotonin-norepinephrine reuptake inhibitor (SNRI) (such as Effexor (venlafaxine)), Flexeril (cyclobenzaprine), or Ultram (tramadol).	PA	PA	PA
Lyrica CR	Coverage requires documentation to support the following: 1. Diagnosis of diabetic neuropathic pain or post-perpetic neuralgia a. If patient ≥ 65 years of age: After a trial of gabapentin. b. If patient < 65 years of age: After a trial of gabapentin and a tricylic antidepressant, such as amitriptyline, desipramine or imipramine. 2. Trial and failure of immediate release Lyrica	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Mavyret	Coverage is provided for: • Members 18 years of age or older • Fibrosis staging score of greater than or equal to F2 • Member has no cirrhosis or compensated cirrhosis • Treatment of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 and trial and failure to Epclusa or Zepatier. • Treatment of hepatitis C genotype 1 members who have previously received treatment with a preferred hepatitis C regimen (such as Epclusa or Zepatier) and who meet clinical criteria Drugs will be reviewed on a case by case basis using the AASLD guidelines and FDA approved package labelling and trial and failure to Epclusa or Zepatier.	PA	PA	PA
Mekinist*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Menopur	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice. Coverage also requires treatment failure of or intolerance to Gonal-F, -RFF, Redi-ject.	PA	PA	Not Covered
Mirapex ER (pramipexole di-hcl)	Coverage is provided for the treatment of Parkinson's disease in situations where the member has experienced treatment failure of or intolerance to Mirapex IR (pramipexole).	PA	PA	Not Covered
Mircera	Coverage is provided for the treatment of FDA approved indications in situations where the member has experienced treatment failure of or intolerance to Procrit.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Movantik	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza	PA	PA	Not Covered
Myalept	Coverage is provided for the treatment of generalized lipodystrophy in situations where the member is optimally treated with insulin and a statin (such as Zocor (simvastatin)).	PA	PA	PA
Myrbetriq	Coverage is provided in situations where the member has experience treatment failure of or intolerance to at least two generic alternatives (such as Detrol (tolterodine) or Ditropan (oxybutynin)).	PA	PA	PA
Mytesi	Coverage is provided for members with HIV/AIDS who are currently on antiretroviral therapy for the treatment of symptomatic relief of non-infectious diarrhea.	ST	ST	ST
Namenda XR	Coverage requires documentation to support the following: Trial of generic memantine immediate release (Namenda IR).	ST	ST	Not Covered
Namzaric	Coverage requires documentation to support the following: Already stable on memantine (Namenda) and donepezil (Aricept).	PA	PA	Not Covered
Nasonex (mometasone furoate)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Flonase (fluticasone propionate) or Nasalide (flunisolide)/Nasarel (flunisolide) AND Nasacort AQ (triamcinolone acetonide).	ST	Not Covered	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Natpara	Coverage is provided for the treatment of hypocalcemia associated with documented hypoparathyroidism in situations where the member is currently being treated with both calcium and Rocaltrol (calcitriol) and is not well controlled.	PA	PA	PA
Natesto	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1.Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered
Nerlynx*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Nesina	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	Not Covered
Neupro	Coverage is provided for the treatment of Parkinson's disease or restless leg syndrome in situations where the member has experienced treatment failure of or intolerance to Mirapex/ER (pramipexole) AND Requip/XL (ropinirole)**.** • **Restless leg syndrome:** Coverage also requires treatment failure of or intolerance to Neurontin (gabapentin).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Nexavar*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Nexium suspension	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to all of the following: Aciphex (rabeprazole), Prevacid (lansoprazole), Prilosec (omeprazole) or Prilosec OTC, AND Protonix (pantoprazole), one of which is at a twice daily, high dose regimen.	PA	Not Covered	PA
Nicotrol, NS	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to a generic nicotine replacement product (gum, lozenge, or patch) or Zyban (bupropion).	ST	ST	ST
Ninlaro*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Noctiva	Coverage requires documentation to support 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	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Norditropin FlexPro	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Northera	Coverage is provided for members 18 years of age or older for the treatment of symptomatic neurogenic orthostatic hypotension in situations where the member has experienced treatment failure of or intolerance to Florinef (fludrocortisone) AND Proamatine (midodrine).	PA	PA	Not Covered
Novarel	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	PA
Nucynta	Coverage requires documentation to support the following: 1. Treatment failure or intolerance to generic immediate-release tramadol or tramadol/acetaminophen 2. Treatment failure or intolerance to two preferred immediate release narcotics, such as generic Percocet, generic immediate release morphine. Authorization: 1 year Renewal requires recent documentation since the previous approval of an updated treatment plan and that the medication has been safe and effective.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Nucynta ER	**Moderate to severe chronic pain:** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Ultram ER (tramadol) AND two of the following preferred long-acting agents: Duragesic (fentanyl), methadone, or MS Contin (morphine). **Diabetic peripheral neuropathy:** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to: • Members < 65 years: Neurontin (gabapentin), a tricyclic antidepressant (such as Elavil (amitriptyline)) and Cymbalta (duloxetine). • Member > 65 years: Neurontin (gabapentin) and Cymbalta (duloxetine). **Note**: Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA
Nuedexta	Coverage is provided for the treatment of pseudobulbar affect (PBA) due to a documented underlying neurological condition (such as multiple sclerosis or stroke).	PA	PA	PA
Nuplazid	Coverage is provided for the treatment of Parkinson's disease psychosis.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Nutropin AQ, Nuspin	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA
Nuvigil (armodafinil)	Coverage is provided for the treatment of narcolepsy or obstructive sleep apnea in situations where the member has experienced treatment failure of or intolerance to Provigil (modafinil). Coverage is not provided for shift-work sleep disorder.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Ocaliva	Coverage is provided for the treatment of primary biliary cirrhosis (PBC) that has been confirmed by at least two of the following tests: 1) positive antimitochondrial antibody (AMA); 2) elevated serum alkaline phosphatase (ALP); 3) histologic evidence of PBC based on liver biopsy. In addition, the member must have experienced an inadequate response to at least one year of treatment with ursodeoxycholic acid (such as Actigall (ursodiol)) and treatment must be continued in combination with Ocaliva. Continued coverage is provided in situations where the member has experienced an improvement in biochemical response (i.e., ALP levels less than 1.67 x ULN, at least 15% decrease in ALP for patients whose baseline ALP levels were between 1.67 and 2.0 x ULN, and/or total bilirubin < ULN at 12 months).	PA	PA	PA
Odactra	Coverage requires documentation to support the following: 1. 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. 2. Not receiving allergen specific immunotherapy injections 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist	PA	PA	Not Covered
Odomzo*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Ofev	Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF).	PA	PA	PA
Olysio	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Members taking Olysio must be receiving combination therapy with Sovaldi OR peginterferon alfa plus ribavirin. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to Zepatier or Epclusa.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Omnaris	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Flonase (fluticasone) or Nasalide (flunisolide)/Nasarel (flunisolide) AND Nasacort AQ (triamcinolone).	ST	Not Covered	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Omnitrope	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Onfi	Coverage is provided for members 2 years of age or older for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in situations where the member has experienced treatment failure of or intolerance to at least two generic anticonvulsants, one of which is Klonopin (clonazepam).	PA	PA	PA
Onzetra Xsail	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Imitrex (sumatriptan) nasal spray AND one other generic triptan (such as Maxalt/MLT (rizatriptan)). In addition, a credible explanation why Onzetra Xsail is expected to work when Imitrex (sumatriptan) nasal spray did not must also be provided to the plan.	PA	PA	Not Covered
Opana ER (oxymorphone hcl)	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate extended release), methadone, Butrans (buprenorphine), Ultram ER (tramadol extended release), AND Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	Not Covered
Opsumit	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Oracea	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Monodox (doxycycline monohydrate).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Oralair	Coverage is provided for the treatment of allergic rhinitis with or without conjunctivitis with confirmed sensitivity to at least one allergen contained in the requested agent in members who have experienced treatment failure of or intolerance to all of the following drug classes: an intranasal corticosteroid (such as Flonase (fluticasone)), an antihistamine (such as Zyrtec (cetirizine)) and a leukotriene inhibitor (such as Singulair (montelukast)).	PA	PA	Not Covered
Orencia, Clickject, sub-q	Coverage requires documentation to support the following: 1. Age 18 years and older 2. Rheumatoid arthritis and when patient has tried a three month trial of Disease Modifying Anti-Rheumatic Drug (DMARD) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine) and failed TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR 3. Psoriatic arthritis when patient has tried a three month trial of DMARD and failed TWO of the following: Cosentyx, Enbrel, Humira, or Stelara. OR 1. Two years or older 2. Juvenile idiopathic arthritis (JIA) and when patient has tried a three month trial DMARD 3. Trial and treatment failure of Enbrel and Humira.	PA	PA	PA
Orenitram ER	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Orkambi	Coverage is provided for the treatment of cystic fibrosis in members 6 years of age or older in situations where the member has confirmed two copies of the F508del mutation in the CFTR gene AND where genetic testing results are submitted to the plan. In addition, the member must have a baseline FEV1 predicted of 30% or greater and must be receiving other chronic maintenance treatment (such as hypertonic saline or dornase alfa).	PA	PA	PA
Oseni	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	Not Covered
Otezla	Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis. Coverage is provided for members 18 years of age or older for the treatment of psoriatic arthritis in situations where the member has experienced treatment failure of or intolerance to ONE of the following: Cosentyx, Enbrel, Humira, or Stelara.	PA	PA	PA
Otrexup	Coverage is provided for the treatment of FDA approved indications in situations where the member has experienced treatment failure of or intolerance to both oral and intramuscular methotrexate and a credible explanation as to why subcutaneous methotrexate is expected to work when the other formulations have not must be submitted to the plan.	PA	PA	Not Covered
Ovidrel	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Oxycodone hcl ER	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate), methadone, Butrans (buprenorphine), Ultram ER (tramadol), AND Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA
Oxycontin	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate), methadone, Butrans (buprenorphine), Ultram ER (tramadol), AND Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA
Ozempic	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or Bydureon Bcise, Trulicity and Victoza	PA	PA	Not Covered
Pennsaid 2%	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to an OTC topical analgesic (Aspercreme OR Myoflex), Pennsaid 1.5% (diclofenac sodium) and Voltaren/XR (diclofenac sodium) tablets.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Perforomist	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to both salmeterol (such as Advair or Serevent) AND formoterol (such as Dulera, Foradil, or Symbicort).	ST	ST	ST
Pexeva	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three generic antidepressants, one of which is Paxil (paroxetine).	PA	PA	PA
Picato	Coverage is provided for the treatment of actinic keratosis in situations where the member has experienced treatment failure of or intolerance to three different treatment courses of cryotherapy and two formulary alternatives (such as Aldara (imiquimod), Efudex (fluorouracil) or Retin-A (tretinoin)).	ST	ST	ST
Pomalyst*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Praluent	Coverage is provided for FDA approved indications in members with uncontrolled LDL despite adherence with maximally tolerated concurrent treatment with all of the following for a minimum of three months unless contraindicated: i. Lifestyle modification (e.g. heart-healthy diet, regular exercise, tobacco avoidance) ii. High intensity statin (such as Crestor 20 mg (rosuvastatin)) iii. Zetia (ezetimibe) iv. A preferred bile acid sequestrant (such as Welchol (colesevelam)) v. Prescriber must be a cardiologist, endocrinologist, or board certified lipidologist. vi. Members with statin intolerance must have tried at least 3 different statins in the absence of drug interactions (consider at least one non-daily long-acting statin dosing regimen).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Pregnyl	Coverage is provided for most BCN members with an infertility benefit for treatment of an FDA-approved indication and also in accordance with generally accepted medical practice. BCN does not provide coverage for infertility drugs to be used as part of assisted reproductive technology treatment, such as in-vitro fertilization (IVF), zygote in vitro fertilization transfer (ZIFT), or gamete in vitro fertilization transfer (GIFT). Requests for additional coverage will be based on documentation that the member is being treated according to accepted medical practice.	PA	PA	PA
Prestalia	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Lotrel (amlodipine/benazepril) AND the individual agents used in combination at doses similar to the combination product. A credible explanation as to why Prestalia is expected to work if the individual agents in combination did not must be provided to the plan.	PA	PA	Not Covered
Prevacid Solutab	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to TWO generic proton pump inhibitors (such as Prilosec (omeprazole)).	ST	Not Covered	Not Covered
Prilosec suspension	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Prevacid Solutab.	PA	Not Covered	Not Covered
Procentra (dextroamphetamine)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Adderall XR AND Metadate CD (methylphenidate), both of which may be opened and sprinkled on applesauce.	PA	PA	PA
Procrit	Coverage is provided for treatment of FDA approved indications in situations where the member has a hemoglobin level less than 10 g/dL for initial therapy. For continued coverage, the member's hemoglobin level must be less than 12 g/dL.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Procysbi	Coverage is provided for the treatment of nephropathic cystinosis in situations where the member has experienced treatment failure of or intolerance to Cystagon and a credible explanation as to why Procysbi is expected to work when Cystagon did not is submitted to the plan.	PA	PA	Not Covered
Promacta	Coverage is provided for treatment of FDA approved indications in situations where the member's current platelet count is submitted to the plan and when the member has failed other therapies (e.g. corticosteroids). Continued coverage is approved for members with a current platelet count less than 400,000/mcL.	PA	PA	PA
Protonix suspension	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Prevacid Solutab.	PA	Not Covered	Not Covered
Provigil (modafinil)	Coverage is provided for the treatment of narcolepsy or obstructive sleep apnea. Coverage is not provided for shift-work sleep disorder.	PA	PA	PA
Qnasl	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Flonase (fluticasone propionate) or Nasalide (flunisolide)/Nasarel (flunisolide) AND Nasacort AQ (triamcinolone acetonide).	ST	Not Covered	Not Covered
Qsymia	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia in situations where the member has experienced treatment failure of or intolerance to generic phentermine. Maximum benefit is limited to 12 months of treatment.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Qudexy XR	Coverage requires documentation to support the following 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives, one of which must be generic topiramate (Topamax) OR Currently stable on Qudexy XR for the treatment of seizures OR 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to 3 generic alternatives for the treatment of migraine prevention, one of which must be generic topiramate (Topamax).	PA	PA	Not Covered
Quillichew ER	Coverage is provided for members 6 years of age or older for the treatment of attention deficit hyperactivity disorder (ADHD) in situations where the member has experienced treatment failure of or intolerance to both a methylphenidate product (such as Concerta (methylphenidate) or Ritalin (methylphenidate)) AND an amphetamine product (such as Adderall (dextroamphetamine /amphetamine)), one of which must be a generic long acting formulation OR the physician provides documentation the member cannot swallow tablets/capsules and has experienced treatment failure of or intolerance to one of the agents that can be opened and sprinkled on applesauce (such as Adderall XR or Metadate CD (methylphenidate)).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Quillivant XR	Coverage is provided for members 6 years of age or older for the treatment of attention deficit hyperactivity disorder (ADHD) in situations where the member has experienced treatment failure of or intolerance to both a methylphenidate product (such as Concerta (methylphenidate) or Ritalin (methylphenidate)) AND an amphetamine product (such as Adderall (dextroamphetamine /amphetamine)), one of which must be a generic long acting formulation OR the physician provides documentation the member cannot swallow tablets/capsules and has experienced treatment failure of or intolerance to one of the agents that can be opened and sprinkled on applesauce (such as Adderall XR or Metadate CD (methylphenidate)).	PA	PA	Not Covered
Ragwitek	Coverage is provided for the treatment of allergic rhinitis with or without conjunctivitis with confirmed sensitivity to at least one allergen contained in the requested agent in members who have experienced treatment failure of or intolerance to all of the following drug classes: an intranasal corticosteroid (such as Flonase (fluticasone propionate)), an antihistamine (such as Zyrtec (cetirizine)) and a leukotriene inhibitor (such as Singulair (montelukast)).	PA	PA	Not Covered
Ranexa	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to both a beta-blocker (such as Toprol XL (metoprolol)) and a maintenance nitrate (such as Imdur (isosorbide mononitrate)) given around-the-clock.	PA	PA	PA
Rasuvo	Coverage is provided for the treatment of FDA approved indications in situations where the member has experienced treatment failure of or intolerance to both oral and intramuscular methotrexate and a credible explanation as to why subcutaneous methotrexate is expected to work when the other formulations have not must be submitted to the plan.	PA	PA	Not Covered
Ravicti	Coverage is provided for the treatment of any chronic urea cycle disorder (except for NAGS deficiency) in situations where the member has experienced treatment failure of or intolerance to Buphenyl.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Rayos	Coverage is provided for the treatment of rheumatoid arthritis in situations where the member has experienced treatment failure of or intolerance to two generic oral corticosteroids, one of which must be prednisone immediate-release. In addition, a credible explanation as to why Rayos is expected to work if prednisone immediate-release has not must be submitted to the plan.	PA	PA	Not Covered
Relistor tablet	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza	PA	PA	Not Covered
Relpax (eletriptan)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic triptans (such as Imitrex (sumatriptan) or Maxalt (rizatriptan)).	ST	ST	ST
Repatha	Coverage is provided for FDA approved indications in members with uncontrolled LDL despite adherence with maximally tolerated concurrent treatment with all of the following for a minimum of three months unless contraindicated: i. Lifestyle modification (e.g. heart-healthy diet, regular exercise, tobacco avoidance) ii. High intensity statin (such as Crestor 20 mg (rosuvastatin)) iii. Zetia (ezetimibe) iv. A preferred bile acid sequestrant (such as Welchol (colesevelam)) v. Prescriber must be a cardiologist, endocrinologist, or board certified lipidologist. vi. Members with statin intolerance must have tried at least 3 different statins in the absence of drug interactions (consider at least one non-daily long-acting statin dosing regimen).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Revatio (sildenafil citrate)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	N/A	N/A	PA
Revatio suspension	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) when the member is unable to swallow tablets/capsules.	PA	PA	PA
Revlimid*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Rexulti	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone), one of which must be generic aripiprazole (Abilify). Or For a diagnosis of Major Depressive Disorder, requires a trial of an antidepressant in combination with a generic aripiprazole (Abilify), and documentation that Rexulti will be used adjunctively with an antidepressant.	ST	ST	Not Covered
Rozerem	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to three of the following: Ambien (zolpidem), Desyrel (trazodone), Lunesta (eszopiclone), or Sonata (zaleplon).	ST	ST	ST
Rubraca*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Ruconest	Coverage is provided for members 18 years of age or older with a confirmed diagnosis of type 1 or type 2 hereditary angioedema (HAE) for the treatment of acute attacks or short-term prophylaxis in members who have experienced treatment failure of or intolerance to an attenuated androgen (such as Danocrine (danazol) or Oxandrin (oxandrolone)).	PA	PA	PA
Rydapt*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Rytary	Coverage is provided for members who have experienced treatment failure of or intolerance to both Sinemet (carbidopa/levodopa) and Sinemet CR (carbidopa/levodopa) and a credible explanation as to why Rytary is expected to work when both Sinemet (carbidopa/levodopa) and Sinemet CR (carbidopa/levodopa) have not must be submitted to the plan.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Saizen, **Saizenprep**	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Sancuso	Coverage will be provided for: 1. Indication of prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy. 2. Documented treatment/failure with generic ondansetron (Zofran)/ODT and generic granisetron (Kytril). Initial approval: 1 year Renewal requires documentation of continuation of chemotherapy.	ST	ST	ST
Saphris	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic 2nd generation antipsychotics (such as Abilify (aripiprazole) or Seroquel (quetiapine)).	ST	ST	ST
Savella	Coverage is provided for the treatment of fibromyalgia in situations where the member has experienced treatment failure of or intolerance to Neurontin (gabapentin) and at least three of the following: a tricyclic antidepressant (such as Elavil (amitriptyline)), a selective serotonin reuptake inhibitor (such as Zoloft (sertraline)), a serotonin-norepinephrine reuptake inhibitor (such as Effexor (venlafaxine)), Flexeril (cyclobenzaprine), or Ultram (tramadol).	PA	PA	PA
Saxenda	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia. Maximum benefit is limited to 12 months of treatment.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Segluromet	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of three of the following preferred SGLT-2 inhibitors. (Farxiga or Xigduo, Invokana or Invokamet, Jardiance or Synjardy/Synjardy XR).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Serostim	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Signifor	Coverage is provided for members 18 years of age or older who meet the following clinical criteria: a) Hypercortisolism as a result of endogenous Cushing's syndrome. b) Surgical treatment has been ineffective or the member is not a candidate for surgery. c) Treatment failure of or intolerance to Nizoral (ketoconazole) or Lysodren.	PA	PA	PA
Signifor LAR	Coverage is provided for the treatment of acromegaly in situations where the member has experienced treatment failure of or intolerance to ALL of the following: Sandostatin (octreotide)/LAR, Somatuline Depot, and Somavert. Use of the 60 mg also requires inadequate response to therapy with the 40 mg strength.	PA	PA	Not Covered
Siklos	Coverage requires documentation to support the following: 1. Diagnosis of sickle cell anemia 2. Age ≥ 2 years old 3. Unable to swallow capsules	PA	PA	PA
Silenor	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Ambien (zolpidem), Desyrel (trazodone), Lunesta (eszopiclone), Sinequan (doxepin), AND Sonata (zaleplon).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Simponi	Coverage is provided for members 18 years of age or older for the treatment of: • **Ankylosing spondylitis** in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Cosentyx, Enbrel, or Humira. • **Moderate to severe rheumatoid arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Enbrel, Humira, or Xeljanz/XR. • **Psoriatic arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Cosentyx, Enbrel, Humira, or Stelara. Coverage is provided for the treatment of ulcerative colitis in members 18 years of age or older who have experienced treatment failure of or intolerance to an adequate course of systemic corticosteroids or immunomodulatory medication and Humira.	PA	PA	PA
Sirturo	Coverage is provided for members 18 years of age or older for the treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB).	PA	PA	PA
Skelaxin (metaxalone)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three of the following: Flexeril (cyclobenzaprine), Norflex (orphenadrine), Parafon Forte (chlorzoxazone), or Robaxin (methocarbamol)**.**	PA	PA	PA
Solaraze (diclofenac sodium)	Coverage is provided for the treatment of actinic keratosis in situations where the member has experienced treatment failure of or intolerance to three different treatment courses of cryotherapy and two formulary alternatives (such as Aldara (imiquimod), Efudex (fluorouracil) or Retin-A (tretinoin)).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Soliqua 100-33	Coverage requires documentation to support the following: 1. Diagnosis of type II diabetes mellitus. 2. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 3. Trial for at least 3 months of the preferred medication, Xultophy.	PA	PA	Not Covered
Soma (carisoprodol)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least three of the following: Flexeril (cyclobenzaprine), Norflex (orphenadrine), Parafon Forte (chlorzoxazone)**,** or Robaxin (methocarbamol).	N/A	N/A	PA
Sovaldi	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Members taking Sovaldi must be receiving combination therapy with peg-interferon and/or ribavirin. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to Zepatier or Epclusa.	PA	PA	PA
Spritam	Coverage requires all of the following be met: 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.	PA	PA	Not Covered
Sprycel*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Staxyn	Coverage is provided for male members for the treatment of erectile dysfunction in situations where the member has experienced treatment failure of or intolerance to Revatio (sildenafil). Maximum of 6 doses per 28 days.	PA	PA	Not Covered
Steglatro	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of three of the following preferred SGLT-2 inhibitors. (Farxiga or Xigduo, Invokana or Invokamet, Jardiance or Synjardy/Synjardy XR).	PA	PA	Not Covered
Steglujan	Coverage requires documentation to support the following: 1. Trial of at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of three of the following preferred SGLT-2 inhibitors. (Farxiga or Xigduo, Invokana or Invokamet, Jardiance or Synjardy/Synjardy XR).	PA	PA	Not Covered
Stelara	Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis or psoriatic arthritis. Coverage is provided for the treatment of Crohn's disease in members 18 years of age or older.	PA	PA	PA
Stendra	Coverage is provided for male members for the treatment of erectile dysfunction in situations where the member has experienced treatment failure of or intolerance to Revatio (sildenafil). Maximum of 6 doses per 28 days.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Stivarga*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Striant	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency Renewal criteria: 1. Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency	ST	ST	Not Covered
Strensiq	Coverage is provided for the treatment of pediatric-onset hypophosphatasia in situations where clinical documentation of the member's active disease manifestations has been submitted to the plan.	PA	PA	PA
Subsys	Coverage is provided for the treatment of breakthrough cancer pain in members that are tolerant of high dose narcotics and who are currently receiving a long-acting narcotic. The member must also have experienced treatment failure of or intolerance to the use of Actiq (fentanyl) and other oral immediate-release narcotics for the management of breakthrough pain.	PA	PA	Not Covered
Subutex (buprenorphine hcl)	Coverage under the pharmacy benefit is provided for the treatment of opioid dependence in situations where the member is currently pregnant or breastfeeding.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Sumavel Dosepro	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Imitrex (sumatriptan) injection AND one other generic triptan (such as Maxalt/MLT (rizatriptan)). In addition, a credible explanation why Sumavel DosePro or Zembrance Symtouch is expected to work when Imitrex (sumatriptan) injection did not must also be provided to the plan.	ST	ST	Not Covered
Sutent*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Symlinpen	Coverage is provided for members 18 years of age or older for the treatment of diabetes mellitus in members who are receiving mealtime insulin therapy and have not achieved desired glucose goal despite good compliance with optimal insulin therapy.	PA	PA	PA
Symproic	Coverage requires documentation to support the following: 1. Diagnosis of opioid induced constipation 2. Age ≥ 18 years of age 3. Trial and failure or intolerance to all of the following: a. Osmotic laxative b. Stimulant laxative used in combination with a stool softener c. Amitiza	PA	PA	Not Covered
Syprine	Coverage is provided for the treatment of Wilson's disease in situations where the member has experienced treatment failure of, intolerance to, or contraindication to Depen.	PA	PA	PA
Taclonex ointment (calcipotriene/beta methasone)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least 30 days of treatment with the combination of a very high potency corticosteroid (such as Diprolene ointment (betamethasone), Psorcon (diflorasone), or Temovate (clobetasol)) plus Dovonex (calcipotriene).	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Taclonex topical suspension	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to at least 30 days of treatment with the combination of a very high potency corticosteroid (such as Diprolene ointment (betamethasone), Psorcon (diflorasone), or Temovate (clobetasol)) plus Dovonex (calcipotriene).	PA	PA	PA
Tafinlar*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Taltz	Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis in situations where the member has experienced treatment failure of or intolerance to at least two of the following: Cosentyx, Humira, Otezla, and Stelara.	PA	PA	Not Covered
Tagrisso*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Tamoxifen*	Female members qualify for a $0 copayment when the following clinical criteria are met: Coverage is provided for primary prevention of breast cancer in women age 35 years or older with documented risk factors showing the member is at high risk for developing breast cancer and the member has no history of breast cancer, ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS), or a personal/family history of venous thromboembolic events.	PA	PA	PA
Tanzeum	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Bydureon or BudureonBCise, Trulicity and Victoza.	PA	PA	Not Covered
Tarceva*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Targretin capsule* (bexarotene)	Coverage is provided for the treatment of cutaneous T-cell lymphoma (CTCL) in situations where the member has experienced treatment failure of or intolerance to at least one systemic therapy.	PA	PA	PA
Targretin gel	Coverage is provided for the treatment of cutaneous T-cell lymphoma (CTCL) where the member has experienced treatment failure of or intolerance to at least one systemic therapy.	PA	PA	PA
Tasigna*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Technivie	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Members taking Technivie must be receiving combination therapy with ribavirin. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to Zepatier or Epclusa.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Testim	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1.Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered
Testosterone (Brand) 1% gel, packet, pump	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1.Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Thiola	Coverage is provided for the prevention of cystine (kidney) stone formation for members with a urinary cystine concentration greater than 500 mg/day who are refractory to ALL of the following treatments: increased fluid intake, restriction of sodium and animal protein, and urine alkalinization therapy with Urocit-K (potassium citrate). Continuation of therapy requires urinary cystine concentration less than 250 mg/L.	PA	PA	PA
Tobi Podhaler	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in cystic fibrosis in situations where the member has experienced treatment failure of or intolerance to generic inhaled tobramycin (such as Tobi (tobramycin in 0.225% sodium chloride)) and a credible explanation as to why the requested product is expected to work when the generic product has not has been submitted to the plan.	PA	PA	Not Covered
Topiramate ER	Coverage requires documentation to support 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 Currently stable on Topiramate ER for the treatment of seizures OR 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to three generic alternatives for the treatment of migraine prevention, one of which must be generic Topamax	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Tracleer	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Tradjenta	Coverage will be provided when the member has experienced treatment failure or intolerance to one generic oral diabetes drug (such as metformin), Januvia and Onglyza.	ST	ST	ST
Tremfya	Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis in situations where the member has experienced treatment failure of or intolerance to Humira.	PA	PA	PA
Treximet	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to a combination of Imitrex (sumatriptan) with naproxen, and one other generic triptan (such as Maxalt/MLT (rizatriptan benzoate)).	PA	PA	Not Covered
Trintellix	Requires trial and failure of at least three generic or preferred antidepressant agents.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Trokendi XR	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least three generic alternatives, one of which is generic topiramate (Topamax) OR Currently stable on Topiramate ER for the treatment of seizures OR 1. Member is 12 years of age or older 2. Prescribed for prevention of migraine headaches 3. Treatment failure or intolerance to three generic alternatives for the treatment of migraine prevention, one of which must be generic Topamax	PA	PA	Not Covered
Tykerb*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Tymlos	Coverage is provided for the treatment of osteoporosis in situations where the member has a contraindication to or has experienced treatment failure of or intolerance to a preferred bisphosphonate (such as Actonel (risedronate))**.**	PA	PA	PA
Tyvaso	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Uceris foam	Coverage requires documentation to support the following: 1. Trial of a preferred corticosteroid enema or foam 2. Trial of generic rectal mesalamine.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Uceris tablet	Coverage is provided for the treatment of active, mild to moderate ulcerative colitis in situations where the member has experienced treatment failure of or intolerance to an oral aminosalicylate (5-ASA) AND two oral, locally active corticosteroids, one of which is Entocort EC™ (budesonide).	PA	PA	Not Covered
Uloric	Coverage is provided for the treatment of gout in situations where the member has experienced treatment failure of or intolerance to Zyloprim (allopurinol).	ST	ST	ST
Uptravi	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Valchlor	Coverage is provided for the treatment of Stage 1A or 1B mycosis fungoides type cutaneous T-cell lymphoma in situations where the member has experienced treatment failure of or intolerance to at least two skin-directed therapies: 1. Topical carmustine or topical retinoid AND 2. Phototherapy or total skin electron beam therapy.	PA	PA	PA
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) Initial approval 1 year Renewal requires documentation of continuation of chemotherapy	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Vascepa	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to ALL of the following: Lopid (gemfibrozil), an OTC omega-3 fatty acid at a dose of at least 3 grams/day, a generic fenofibrate (i.e. Antara (fenofibrate, micronized), Lofibra (fenofibrate), or Tricor (fenofibrate nanocrystallized)), AND Lovaza (omega-3 acid ethyl esters). Also requires triglyceride levels $\geq$ 500 mg/dl.	PA	PA	Not Covered
Vecamyl	Coverage is provided for the treatment of moderately severe to severe primary hypertension or uncomplicated cases of malignant hypertension in members who have experienced treatment failure of or intolerance to three antihypertensive drug combinations (such as Zestril (lisinopril) plus Diuril (chlorothiazide) or Lopressor HCT (metoprolol/hydrochlorothiazide).	PA	PA	Not Covered
Venclexta*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Ventavis	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).	PA	PA	PA
Verzenio*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Viagra (sildenafil citrate)	Coverage is provided for male members for the treatment of erectile dysfunction in situations where the member has experienced treatment failure of or intolerance to Revatio (sildenafil). Maximum of 6 doses per 28 days.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Viberzi	Coverage is provided for the treatment of diarrhea-predominant irritable bowel syndrome (IBS-D) in adult members who have experienced treatment failure of or intolerance to ALL of the following: Imodium (loperamide); a tricyclic antidepressant (for example, Pamelor (nortriptyline)) OR selective serotonin reuptake inhibitor (for example (Prozac (fluoxetine)); and an antispasmodic (for example, Bentyl (dicyclomine)).	PA	PA	Not Covered
Viibryd, dosepak	Requires trial and failure of at least three generic or preferred antidepressant agents	PA	PA	PA
Vogelxo	Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI > 30, two morning free testosterone levels must be submitted. 3. At least two signs or symptoms specific to testosterone deficiency 4. Trial and treatment failure or intolerance to Androgel and Androderm Renewal criteria: 1.Testosterone levels are at or below normal range. 2. Improvement in signs or symptoms specific to testosterone deficiency.	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Vosevi	Coverage is provided for members 18 years of age or older for • Fibrosis staging score of greater than or equal to F2 • Member has no cirrhosis or has compensated cirrhosis • Trial and failure to preferred medication: Epclusa or Zepatier • Treatment of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 with a fibrosis staging score of greater than or equal to F2 and have previously been treated with an NS5A (nonstructural protein 5A) inhibitor and who meet clinical criteria. • Treatment of chronic hepatitis C genotype 1a or 3 with a fibrosis staging score of greater than or equal to F2, have previously failed sofosbuvir containing regimen without an NS5A inhibitor and who meet clinical criteria. Coverage is reviewed on a case by case basis using the AASLD guidelines, FDA approved package labelling, and trial and failure to preferred agent.	PA	PA	PA
Votrient*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Vraylar	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic 2nd generation antipsychotics (such as Abilify (aripiprazole) or Seroquel (quetiapine)).	ST	ST	ST
Vyzulta	Coverage requires documentation to support the following: 1. Diagnosis of elevated intraocular pressure 2. Trial of all preferred medications (generic Xalatan, generic Lumigan, Travatan Z)	PA	PA	Not Covered
Xalkori*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Xeljanz, XR	Coverage is provided for members 18 years of age or older for the treatment of rheumatoid arthritis.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Xenazine (tetrabenazine)	Coverage is provided for the treatment of chorea associated with Huntington's disease.	PA	PA	PA
Xenical	Coverage is provided for members 18 years of age or older with a body mass index (BMI) of ≥ 30 kg/m2 or ≥ 27 kg/m2 with documentation of one or more of the following risk factors: hypertension, congestive heart failure, coronary artery disease, diabetes or dyslipidemia. Maximum benefit is limited to 24 months of treatment.	PA	PA	Not Covered
Xermelo	Coverage requires documentation to support the following: 1. Diagnosis of carcinoid syndrome diarrhea 2. Age ≥ 18 years old 3. Trial and treatment failure of somastatin analog (SSA) (octreotide, lanreotide) 4. Using in combination with SSA.	PA	PA	PA
Xifaxan 550 mg	**Hepatic encephalopathy:** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to lactulose. Approval duration: up to 10 years **Diarrhea-predominant irritable bowel syndrome (IBS-D):** Coverage is provided in situations where the member has experienced treatment failure of or intolerance to ALL of the following: Imodium (loperamide); a tricyclic antidepressant (such as Pamelor (nortriptyline)) OR selective serotonin reuptake inhibitor (such as Prozac (fluoxetine)); and an antispasmodic (such as Bentyl (dicyclomine)). Approval duration: 14 days. Maximum 3 treatment courses per lifetime.	PA	PA	PA
Xuriden	Coverage is provided for the treatment of hereditary orotic aciduria.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Xyrem	Coverage is provided for the treatment of narcolepsy with cataplexy. For members with a confirmed diagnosis of narcolepsy with excessive day time sleepiness, coverage is provided in situations where the member has experienced treatment failure of or intolerance to either a generic methylphenidate product (such as Ritalin (methylphenidate)) or a generic amphetamine product (such as Adderall (dextroamphetamine /amphetamine)) AND Provigil (modafinil) at doses up to 400 mg per day.	PA	PA	PA
Zanaflex capsule (tizanidine hcl)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to ALL of the following: baclofen, Flexeril (cyclobenzaprine), and Zanaflex tablets (tizanidine).	PA	PA	PA
Zavesca	Coverage is provided for members 18 years of age or older for the treatment of Type 1 Gaucher's disease for whom enzyme replacement therapy is not a therapeutic option (eg, because of allergy, hypersensitivity, or poor venous access). Continued coverage may be authorized for members by providing documentation of stability or improvement in disease.	PA	PA	PA
Zegerid (omeprazole/sodium bicarbonate) (Rx Only)	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to three generic proton pump inhibitors (such as Prilosec (omeprazole)).	PA	Not Covered	Not Covered
Zejula*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Zelboraf*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zembrace Symtouch	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Imitrex (sumatriptan) injection AND one other generic triptan (such as Maxalt/MLT (rizatriptan)). In addition, a credible explanation why Zembrance Symtouch is expected to work when Imitrex (sumatriptan) injection did not must also be provided to the plan.	PA	PA	Not Covered
Zepatier	Coverage is provided for members 18 years of age or older for the treatment of chronic hepatitis C for genotypes 1 and 4 with a fibrosis staging score of greater than or equal to F2 who meet clinical criteria. Coverage is reviewed on a case by case basis using the AASLD guidelines and FDA approved package labelling.	PA	PA	PA
Zetonna	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Flonase (fluticasone propionate) or Nasalide (flunisolide)/Nasarel (flunisolide) AND Nasacort AQ (triamcinolone acetonide).	ST	Not Covered	Not Covered
Zinbryta	Coverage is provided for the treatment of relapsing forms of multiple sclerosis in situations where the member has experienced treatment failure of or intolerance to ALL of the following: an interferon beta product (such as Avonex), Copaxone, Gilenya and Tecfidera.	PA	PA	Not Covered
Zohydro ER	Coverage is provided for the treatment of moderate to severe chronic pain requiring around-the-clock, long-term opioid treatment in situations where the member has experienced treatment failure of or intolerance to an adequate trial with at least TWO of the following: MS Contin (morphine sulfate), methadone, Butrans (buprenorphine), Ultram ER (tramadol), AND Duragesic (fentanyl). **Note:** Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.	PA	PA	PA
Zolinza*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zolpimist	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to three of the following: Ambien (zolpidem), Desyrel (trazodone), Lunesta (eszopiclone), or Sonata(zaleplon).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zomacton	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zomig nasal spray	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic triptans (such as Imitrex (sumatriptan) or Maxalt (rizatriptan)).	ST	ST	ST

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zorbtive	**Children (<18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency who have not received a renal transplant, growth failure in children small for gestational age or with intrauterine growth retardation, Turner's Syndrome, Noonan's Syndrome, Prader-Willi Syndrome, SHOX deficiency, or for treatment of severe burns covering > 40% of the total body surface area. The member's current height and weight must be provided. The member must also have open epiphyses. • **Initial treatment:** For growth hormone deficiency, test results confirming diagnosis must be provided. The member's height must be below the 5th percentile, and epiphyses must be confirmed as open. • **To continue:** The member must achieve a growth velocity of > 4.5 cm/year while receiving therapy over the past year. Treatment may continue until final height or epiphyseal closure has been documented. **Adults (≥ 18 years of age):** Coverage is provided for the treatment of growth hormone deficiency, AIDS wasting cachexia, Turner's Syndrome and Short Bowel Syndrome (SBS). The diagnosis of growth hormone deficiency must be based on one of the following: 1) two failed growth hormone stimulation tests, 2) three or more pituitary hormone deficiencies other than growth hormone (for example TSH) with an IGF-1 below 80 ng/ml, or 3) failure of one growth hormone stimulation test and at least one pituitary hormone deficiency OR one GH stimulation test or subnormal IGF-1 level AND any of the following: defined CNS pathology, history of irradiation/surgery/trauma, multiple pituitary hormone deficiency or a genetic defect affecting the growth hormone axis. Approval duration: up to 10 years (exception: SBS 1 month) Coverage also requires the member has experienced treatment failure of or intolerance to all preferred agents (Genotropin, Nutropin AQ and Norditropin). **Note:** Treatment for idiopathic short stature is not covered.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zuplenz	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to oral Kytril (granisetron hcl) AND Zofran (ondansetron hcl)/ODT (ondansetron). Initial approval 1 year Renewal requires documentation of continuation of chemotherapy	ST	ST	Not Covered
Zurampic	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Zyloprim (allopurinol), Duzallo and Uloric at maximally tolerated doses, and where Zurampic will be used in combination with a xanthine oxidase inhibitor (such as Zyloprim (allopurinol)). Treatment failure is defined as serum uric acid level > 6 mg/dL despite treatment with maximally tolerated doses of Zyloprim (allopurinol) and Uloric. Additional coverage criteria applies to Uloric.	PA	PA	Not Covered
Zydelig*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Zykadia*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Zytiga*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA

Notes:

***Note**: Coverage also may be provided if the member is enrolled in a Phase II-IV investigative study and documentation of enrollment and study approval by an appropriate investigational review board (IRB) is submitted to the plan.