Blue Care Network
Prior Approval and Step Therapy Guidelines
November 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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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 requires documentation to support the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine OR 1. Diagnosis of Juvenile Idiopathic Arthritis 2. Age ≥ 2 years old 3. Trial and treatment failure of one DMARD 4. Trial and treatment failure with Humira or Enbrel OR 1. Diagnosis of giant cell arteritis 2. Age ≥ 18 years old OR 1. Diagnosis of chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome 2. Age ≥ 2 years old	PA	PA	PA
Acthar H.P.	Coverage is provided for the treatment of infantile spasms (West Syndrome).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Adoxa/Adoxa Pak (doxycycline monohydrate)	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).	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: Byetta, Bydureon/ BudureonBCise, Trulicity and Victoza.	PA	PA	Not Covered
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Afinitor, Disperz*	Coverage requires documentation to support the following: Treatment of an FDA approved indication	PA	PA	PA
Afrezza	Coverage is provided when the member has experienced treatment failure or intolerance to Novolog	PA	PA	Not Covered
Aimovig	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines	PA	PA	PA
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Amphetamine sulfate (Evekeo)	Coverage will be provided when one of the following have been met. (A, B or C): A. Narcolepsy: 1. ≥ 6 years of age, 2. Trial of generic Adderall IR and a generic methylphenidate. B. ADHD: (Attention hyperactivity deficit disorder) 1. 3-6 years of age. i. Trial of an amphetamine or 2. ≥6rs old, i. Trial of an amphetamine and a methylphenidate product. C. Obesity: 1. ≥ 12 years of age, 2. Documentation of BMI > 30 kg/m2, 3. Documentation of lifestyle modifications, and 4. Documentation of previous failed weight loss therapies.	PA	PA	Not Covered
Amrix	Coverage requires previous trial and treatment failure of generic immediate-release cyclobenzaprine (Flexeril).	ST	ST	Not Covered

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. fFor 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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Aranesp	Coverage requires documentation to support the following: 1. FDA approved indication 2. Hemoblogin less than 10 g/dl 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis	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 requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) or 3. Fosamax (alendronate)	ST	ST	ST

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Axert	Requires trial of 2 generic triptans: (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT)	ST	ST	ST
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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 requires documentation to support the following: 1. ≥18 years old 2. Diagnosis of systemic lupus erythematosus (SLE) 3. Trial and treatment failure or intolerance of two or more of the following: hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide or mycophenolate. 4. Does not have severe active lupus nephritis or severe active CNS lupus 5. Not to be used in combination with other biologics, B-cell targeted therapies or IV cyclophosphamide	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Bethkis	Coverage requires documentation to support the following: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa. 2. Trial of generic tobramycin inhalation nebulization solution	PA	PA	Not Covered
Binosto	Coverage requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) or 3. Fosamax (alendronate)	ST	ST	Not Covered
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
Braftovi	Coverage requires documentation of the following: 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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Bystolic	Coverage requires documentation to support the following: Trial and treatment failure to at least two preferred cardioselective betablockers such as atenolol (Tenormin), metoprolol (Toprol/XL), bisoprolol (Zebeta), betaxolol (Kerlone)	ST	ST	ST
Cabometyx*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Calcipotriene and Betamethasone ointment (**Taclonex**®)	Coverage requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid (ex. generic Diprolene ointment, generic Psorcon, or generic Temovate) And 2. Using high potency topical steroid in combination with generic Dovonex	PA	PA	PA
Calquence*	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
Caprelsa*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Carbaglu	Coverage requires documentation to support the following: 1. Treatment of hyperammonemia due to a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) 2. Deficiency must be 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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Chenodal	Coverage requires documentation to support the following: 1. Treatment of gallstones 2. Ineligible for surgery 3. Treatment failure or intolerance to Actigall (ursodiol) Coverage is limited to 24 months	PA	PA	PA
Cholbam	Coverage requires documentation to support the following: 1. Prescribed by or in consultation with hepatologist or gastroenterologist 2. Treatment of bile acid synthesis disorder due to single enzyme defects (SEDs) OR 1. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestation of liver disease, steatorrhea or complications from decreased fat soluble vitamin deficiency 2. Prescribed by or in consultation with a hepatologist or gastroenterologist	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Cimzia syringe	Coverage requires documentation to support the following: 1. Diagnosis of Crohn's disease 2. Age ≥ 18 years old 3. Trial and treatment failure with an oral systemic therapy (corticosteroid, immunomodulatory medication such as azathioprine, cyclosporine, methotrexate) 4. Trial and treatment failure of Humira or Stelara OR 1. Diagnosis of rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine. 4. Trial and treatment failure to two of the following: Humira, Enbrel, Actemra or Xeljanz/Xeljanz XR. OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure to two of the following: Humira, Enbrel or Cosentyx. OR 1. Diagnosis of psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure with one DMARD 4. Trial and treatment failure of two of the following: Humira, Enbrel, Stelara or Cosentyx. OR 1. Diagnosis of psoriasis 2. Trial and treatment failure of light therapy 3. Trial and treatment failure of a generic oral systemic agent (cyclosporine, methotrexate, acitretin) 4. Trial and treatment failure of two of the following: Cosentyx, Humira, Otezla or Stelara	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Cometriq*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
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
Corlanor	Coverage requires documentation to support the following: 1. Diagnosis of heart failure with left ventricular ejection fraction ≤ 35% 2. Stable on a maximally tolerated dose of one of the following beta blockers: metoprolol succinate, carvedilol or bisoprolol 3. Not to be used in combination with Entresto	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Cosentyx	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Patient is 18 years of age or older 3. Treatment with phototherapy or photochemotherapy was ineffective, contraindicated, or not tolerated 4. Treatment with at least one oral systemic agent for plaque psoriasis was Ineffective or not tolerated, unless contraindicated. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin. Or Diagnosis of psoriatic arthritis 1. Patient is 18 years of age or older 2. Treatment with at least one generic oral systemic agent. (Examples: cyclosporine, methotrexate and lefludomide) Or Age 18 years or older and diagnosis of ankylosing spondylitis	PA	PA	PA
Cotellic*	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
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 requires documentation to support the following: 1. Age 18 years or older 2. Prescribed in conjunction with Sovaldi for the treatment of chronic hepatitis C genotype 1 or 3 3. Documentation of previous treatment experience for Hepatitis C 4. Documentation of compensated or decompensated cirrhosis 5. Prescribed by a hepatologist, gastroenterologist, or infectious disease specialist. 6. Trial of preferred medication: Epclusa or Zepatier Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Dalfampridine ER (Ampyra)	Coverage requires documentation to support the following: 1. Diagnosis of multiple sclerosis. 2. Patient has documented difficulty walking, resulting in significant limitations of instrumental activities of daily living. 3. Clinical notes are provided documenting two measurements with variability within 10% demonstrating the patient is able to walk 25 feet in 8-45 seconds. The faster time of the two measurements will serve as the baseline value. Ambulatory function assessed with the timed 25-foot walk (T25FW). Initial approval length: 6 months Renewal requires the following: 1. Improvement in walking speed by at least 20% as assessed by the timed 25-foot walk test 2. Activities of daily living have improved	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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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: Age ≥ 18 years old **Preoperative treatment:** for members who have experienced treatment failure of or intolerance to a preferred selective alpha1-adrenergic receptor blocker (such as Cardura (doxazosin)) in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)). Approval 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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Doptelet	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Diagnosis of thrombocytopenia in chronic liver disease 3. Platelet count < 50,000 mcL 4. Scheduled to undergo a procedure Approval: 1 month	PA	PA	PA
Doryx/Doryx MPC	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).	PA	PA	Not Covered
Doxepin topical cream	Coverage requires documentation to support the following: 1. Diagnosis of atopic pruritic or lichen simplex chronicus 2. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 3. Trial and treatment failure to one preferred topical calineurin inhibitor (tacrolimus, pimecrolimus OR 1. Diagnosis of peripheral neuropathic pain 2. Trial and treatment failure of two over-the-counter topical analgesics 3. Trial and treatment failure of one preferred topical non-steroidal anti-inflammatory drug (NSAID) Approve for 1 month	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Duopa	Coverage requires documentation to support the following: 1. Diagnosis of advanced Parkinson's disease 2. Member has a feeding tube	PA	PA	PA
Dupixent	Coverage requires documentation to support the following: 1. Age ≥ 18 years' old 2. Prescribed by a dermatologist or allergist 3. Treatment of moderate to severe atopic dermatitis in adults whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable 4. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 5. Trial and treatment failure with one preferred topical calcineurin inhibitor (generic Protopic, Elidel) 6. Trial and treatment failure or contraindication to photochemotherapy (PUVA) 7. Trial and treatment failure or contraindication to one preferred oral systemic agent for atopic dermatitis. (Ex. cyclosporine, methotrexate, azathioprine and mycophenolate mofetil).	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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
Ecoza	Coverage requires documentation to support the following: 1. Age ≥ 12 years old 2. Diagnosis of tinea pedis 3. Treatment failure of 2 topical over-the-counter antifungal agents 4. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)	PA	PA	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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 requires documentation to support the following: 1. Diagnosis of HIV 2. Currently receiving antiretroviral therapy (ART) 3. Documentation of the medical complication caused by excess abdominal fat 4. Medical complication due to excess abdominal fat is unresponsive to conventional therapy. Initial approval: 6 months Renewal: Requires documentation indicating a decrease in waist circumference and reduction of complications caused by excess abdominal fat	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Emflaza	Coverage requires documentation to support the following: 1. Diagnosis of Duchenne Muscular Dystrophy (DMD) 2. Prescribed by or in consultation with a physician who specializes in the treatment of DMD 3. Trial and treatment failure of prednisone or prednisolone.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Enbrel	Coverage requires documentation to support the following: 1. Rheumatoid arthritis or psoriatic arthritis a. Age ≥ 18 years of age b. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD. Examples include methotrexate, sulfasalazine, azathioprine, Hydroxychloroquine/chlorquine, cyclosporine, gold and penicillamine. OR 2. Ankylosing spondylitis a. Age ≥ 18 years old OR 3. Psoriasis a. Age ≥ 4 years old b. Trial of light therapy (unless contraindicated c. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) d. Trial and treatment failure with Humira (age appropriate) OR 4. Juvenile idiopathic arthritis a. Age ≥ 2 years old b. Trial and treatment failure of one DMARD. Examples of DMARDs include methotrexate, sulfasalazine, azathioprine.	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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 requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid in (ex. generic Diprolene ointment, generic Psorcon, generic Temovate) combination with generic Dovonex. 2. Trial and treatment failure with generic Taclonex ointment (requires prior authorization)	PA	PA	Not Covered
Epclusa	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. Documentation of previous treatment experience for Hepatitis C 4. Documentation of compensated or decompensated cirrhosis 5. Prescribed by a hepatologist, gastroenterologist, or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Epidiolex	Coverage requires documentation to support the following: 1. Diagnosis of Lenox-Gastaut or Dravets syndrome 2. Trial and treatment failure of at least 2 generic alternatives	PA	PA	PA
Epiduo Forte	Coverage requires all of the following: 1. Trial of generic Benzaclin or generic Benzamycin 2. Trial of combination of individual agents' benzoyl peroxide 2.5% and adapalene 0.3%	PA	PA	Not Covered
Epogen	Coverage requires documentation to support the following: 1. FDA approved indication 2. Hemoblogin less than 10 g/dl 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.	PA	PA	PA
Erleada	Coverage requires documentation to support the following: Treatment of FDA approved indications	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Eucrisa	Coverage requires documentation to support the following: 1. Age ≥ 2 years old 2. Diagnosis of atopic dermatitis 3. Trial and treatment failure to two topical steroids, one of which must be a medium or high potency product 4. Trial and treatment failure to one preferred topical calcineurin inhibitor (generic Protopic, Elidel)	PA	PA	Not Covered
Evista* (raloxifene)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age and post-menopausal. 2. The medication is being used for prevention of primary breast cancer in members classified as high risk. Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE)	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
Fabior	Coverage requires documentation to support the following: Trial and treatment failure to both generic adapalene (Differin) and generic tretinoin (Retin-A, Avita).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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
Fenoprofen calcium (Nalfon, Fenortho, Profeno)	Coverage requires documentation to support the following: 1. Age ≥18 years old 2. Treatment of mild to moderate pain	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Finacea Foam	Coverage will be provided when all of the following have been met: Trial of all of the following: 1. Generic topical metronidazole 2. Generic topical sulfacetamide 10%-sulfur 5% 3. Generic oral tetracycline, generic doxycycline or generic minocycline	ST	ST	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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Firazyr	Coverage requires documentation to support the following: 1. Diagnosis of type 1 or type 2 hereditary angioedema (HAE) as confirmed by genetic testing or with all the following laboratory findings: a. Normal C1q levels b. C4 levels below the limits of the laboratory's normal reference c. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range	PA	PA	PA
Flector Patch	Coverage requires documentation to support the following: 1. Diagnosis of acute pain due to minor strains, sprains or contusions. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs.	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 requires documentation to support the following: 1. Treatment of osteoporosis 2. Trial and failure or contraindication to an oral generic bisphosphonate (generic Fosamax, generic Boniva, generic Actonel) Forteo will be approved for a maximum of two years.	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 requires documentation to support trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) or 3. Fosamax (alendronate)	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Frova (frovatriptan succinate)	Coverage requires documentation to support the following: Trial of 2 generic triptans (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).	ST	ST	ST
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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 requires documentation to support the following: 1. 18 years of age or older 2. Diagnosis of Short Bowel Syndrome (SBS) 3. Dependent on parenteral support ≥ 12 months	PA	PA	PA
Gelnique	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies	ST	ST	Not Covered

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 and treatment failure of Qtern (dapagliflozin/saxagliptin)	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Gralise	Coverage requires documentation to support the following: 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≤ 65 years of age 3. Trial of generic Neurontin (gabapentin) 4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) Or 1 Diagnosis of post-herpetic neuralgia 2. ≥ 65 years of age 3. Trial of generic Neurontin (gabapentin)	PA	PA	Not Covered
Grastek	Coverage will be provided when all of the following have been met: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Haegarda	Coverage requires documentation to support the following: 1. Diagnosis of type 1 or type 2 hereditary angioedema (HAE) as confirmed by genetic testing or with all the following laboratory findings: a. Normal C1q levels b. C4 levels below the limits of the laboratory's normal reference c. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range 2. Inadequate response or unable to use attenuated androgens (i.e. danazol, stanozol and oxandrolone)	PA	PA	PA
Harvoni	Coverage requires documentation to support the following: 1. Age 12 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. Documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1, and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Hetlioz	Coverage requires documentation to support the following: 1. Diagnosis of Non 24-hour sleep-wake disorder 2. Trial and treatment failure or intolerance to over-the-counter melatonin 3. Trial and treatment failure to Rozerem 4. Age ≥ 18 years old	PA	PA	PA
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Horizant	Coverage requires documentation to support the following: 1. Diagnosis of Restless Leg Syndrome (RLS) 2. Trial and treatment failure of generic Mirapex (pramipexole) 3. Trial and treatment failure of generic Requip/XL (ropinirole) 4. Trial and treatment failure of generic Neurontin (gabapentin) Or 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≤ 65 years of age 3. Trial of generic Neurontin (gabapentin) 4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) Or 1. Diagnosis of post-herpetic neuralgia 2. ≥ 65 years of age 3. Trial of generic Neurontin (gabapentin)	PA	PA	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>:** a. Age ≥ 18 years old b. Trial of light therapy (unless contraindicated) c. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) **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. Diagnosis of non-infectious intermediate uveitis, posterior uveitis or panuveitis. b. Prescribed by ophthalmologist or rheumatologist c. Trial of an oral corticosteroid d. 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
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 requires documentation to support the following: 1. Trial and failure, or intolerance to generic zolpidem extended release (Ambien CR) and 2. Trial and treatment failure or intolerance to generic zaleplon (Sonata). Coverage will not be approved for combination therapy with other sedative hypnotics.	PA	PA	Not Covered
Iressa*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Isotretinoin (13-cis-Retinoic Acid) **Amnesteem** **Claravis** **Myorisan** **Zenatane**	Coverage requires documentation to support the following: 1. Treatment of severe acne 2. Age ≥ 12 years old 3. Trial and treatment failure to one oral antibiotic 4. Trial and treatment failure to three preferred topical therapies	NA	NA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Jynarque	Coverage requires chart notes to support the following: 1. Patient is > 18 years of age 2. Diagnosis of autosomal dominant polycystic kidney disease (ADPKD) 3. Prescribed by, or in consultation with, a nephrologist	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 requires documentation to support the following: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) 2. Receiving optimal adjunctive therapies including a low fat diet and other lipid lowering treatments 3. Trial and treatment failure of Repatha	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
Karbinal ER	Coverage requires trial and treatment failure to generic carbinoxamine and two other generic antihistamines	ST	ST	Not Covered
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 requires documentation to support the following: 1. Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis and related variants as confirmed by a genetic test or positive family history 2. Trial and failure of lifestyle modifications such as diet (potassium intake alterations) and exercise modifications. 3. Trial and treatment failure of acetazolamide.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Kevzara	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis 2. Age ≥ 18 years old 3. Treatment with one DMARD (must be methotrexate unless not tolerated or contraindicated) 4. Treatment with two of the following agents: Enbrel, Humira, Actemra Xeljanz 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 requires documentation to support the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine 4. Trial and treatment failure with two of the following: Actemra, Enbrel, Humira, Xeljanz/Xeljanz XR OR Diagnosis of Neonatal -onset multisystem inflammatory disease	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Kisqali, Kisqali-Femara co-pack*	Coverage requires documentation to support the following: Treatment of FDA approved indications. Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Korlym	Coverage requires documentation of all the following: 1. Member is ≥ 18 years of age 2. Prescriber is an endocrinologist 3. Diagnosis of hypercortisolism as a result of endogenous Cushing's Syndrome 4. Diagnosis of type II diabetes mellitus (DM) or glucose intolerance secondary to hypercortisolism. 5. Surgical treatment has been ineffective or not a candidate for surgery. 6. Treatment failure or intolerance to a steroidogenesis inhibitor (such as ketoconazole or mitotane), unless contraindicated. 7. Failure to achieve blood glucose control with maximally titrated therapy to manage hyperglycemia. Must include at least 3 months of treatment with insulin. 8. Documentation of baseline 2 – hour glucose tolerance test if diagnosis is glucose intolerance. 9. HbA1c is required if diagnosis is type II DM. Renewal Criteria**:** Renewal requires documentation of ≥ 1% reduction in HbA1c from baseline or ≥ 25% improvement in glucose tolerance. Renew authorization: 1 year Annual renewal: Member is stable on med	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Kuvan	Coverage requires documentation to support the following: 1. Treatment of phenylketonuria (PKU) 2. Following a phenylalanine-restricted diet	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
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Livalo	Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic statins, one of which must be high dose (≥ 40 mg) Lipitor (atorvastatin).	ST	ST	ST
Lokelma	Coverage requires documentation to support the following: 1. Treatment of hyperkalemia 2. Trial and treatment failure of a thiazide or loop diurectic if appropriate 3. Trial and treatment failure of Veltassa	PA	PA	PA
Lonsurf*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Luzu	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure of 2 topical over-the-counter antifungal agents 4. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)	PA	PA	Not Covered
Lynparza*	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
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 requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 in patients without any liver damage or with liver damage and having no symptoms from the damage. 3. Documentation of previous treatment experience for Hepatitis C 4. Trial of the preferred medication: Epclusa or Zepatier for patient who are treatment naïve 5. Patients with HCV genotype 1 who have previously been treated with regimens containing an NS5A (nonstructural protein 5A) inhibitor or an NS3/4A protease inhibitor, but not both 6. Documentation of compensated or decompensated cirrhosis 7. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling 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
Mektovi	Coverage requires documentation of the following: 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.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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 requires documentation to support the following: 1. Treatment of FDA approved indications 2. Hemoglobin < 10g/dl if applicable 3. Trial of preferred agent, Procrit Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.	PA	PA	Not Covered
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Mulpleta	Coverage requires documentation to support the following: 1. Age ≥ 18 years old 2. Diagnosis of thrombocytopenia in chronic liver disease 3. Platelet count < 50,000 mcL 4. Scheduled to undergo a procedure Approval: 1 month	PA	PA	PA
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
Naftin, gel	Coverage is provided when all of the following have been met: 1. 18 years of age or older 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure to two topical over-the-counter antifungal agents 4. Treatment failure to two oral generic antifungal agents	PA	PA	Not Covered
Namenda XR	Coverage requires documentation to support the following: Trial of generic memantine immediate release (Namenda IR).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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
Natpara	Coverage requires documentation to support the following: 1. The prescribing physician is an endocrinologist 2. Using as an adjunct to calcium and Vitamin D to control hypocalcaemia in patients with hypoparathyroidism 3. Currently on calcium and Vitamin D and hypocalcaemia is not well controlled.	PA	PA	PA
Nerlynx*	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
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 requires documentation to support the following: 1. Diagnosis of Parkinson's disease 2. Treatment failure or intolerance to generic Mirapex (pramipexole) and generic Requip (ropinirole). Or 1. Diagnosis of Restless leg syndrome 2. Treatment failure or intolerance to generic Mirapex (pramipexole), generic Requip (ropinirole) and generic Neurontin (gabapentin).	PA	PA	Not Covered
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Nityr	Coverage requires documentation of the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	PA	PA	PA
Nocdurna	Coverage requires documentation to support the following: 1. Diagnosis of nocturnal polyuria 2. Lifestyle changes have been tried (including limiting fluids, elvation of legs 3. Treatment failure or intolerance to one generic medication for overactive bladder (OAB) 4. Trial of generic oral desmopressin	PA	PA	Not Covered
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 requires documentation to support the following: 1. Diagnosis of orthostatic hypotension 2. Age ≥18 years old 3. Trial and treatment failure of midodrine 4. Trial and treatment failure of fludrocortisone	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 requires documentation to support the following: 1. Diagnosis of Parkinson's disease psychosis 2. Prescribed by a neurologist or psychiatrist Initial authorization: 1 year Renewal requires documentation of clinically significant improvement in psychosis symptoms	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

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. 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
Olumiant	Coverage requires documentation to support the following: 1. Diagnosis of Rheumatoid Arthritis 2. Trial and treatment failure of an oral DMARD 3. Trial and treatment failure of two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR	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 requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) nasal spray and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).	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 (doxycycline ir dr)	Coverage requires documentation to support the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Oralair	Coverage will be provided when all of the following criteria has been met: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in this product. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Orencia, Clickject, sub-q	Coverage requires documentation to support the following: 1. Diagnosis of Rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine 4. Trial and treatment failure to two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR OR 1. Diagnosis of Juvenile idiopathic arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure to one DMARD 4. Trial and treatment failure to Enbrel and Humira OR 1. Diagnosis of psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one DMARD 4. Trial and treatment failure of two of the following: Cosentyx, Enbrel, Humira or Stelara	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
Orfadin	Coverage requires documentation of the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	PA	PA	PA
Orkambi	Coverage requires documentation of the following: 1. Diagnosis of cystic fibrosis (CF) in patients with two copies of the F508del mutation confirmed by genetic test. 2. Age ≥ 2 years old 3. Prescribed by pulmonologist in a Cystic Fibrosis center Initial approval: 6 months Renewal requires documentation of improvement in Cystic Fibrosis symptoms.	PA	PA	PA
Orilissa	Coverage requires documentation to support the following: 1. Treatment of pain associated with endometriosis 2. Trial of an oral NSAID 3. Trial of two hormone related therapies 4. Age ≥ 18 years old. 150mg: Approval length: 2 years 200mg: Approval length: 6 months	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Otezla	Coverage requires documentation of the following: 1. Psoriatic arthritis: a. ≥ 18 years of age b. Trial of oral Disease Modifying Anti-Rheumatic drug (DMARD) c. Trial of one of the following: Cosentyx, Enbrel, Humira or Stelara Or 2. Psoriasis: a. ≥ 18 years of age b. Trial and treatment failure of one DMARD. Examples include methotrexate, cyclosporine, acitretin c. Trial of light therapy	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
Oxiconazole (Oxistat)	Coverage is provided when all of the following have been met: 1. 12 years of age or older 2. Diagnosis of tinea pedis, tinea cruris or tinea corporis 3. Treatment failure to two topical over-the-counter antifungal agents 4. Treatment failure to two oral generic antifungal agents	PA	PA	Not Covered
Oxtellar XR	Coverage requires documentation to support the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic oxcarbazepine (Trileptal) OR Currently stable on Oxtellar XR for the treatment of seizures	PA	PA	Not Covered
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial of all preferred products: Byetta, Bydureon/ BudureonBCise, Trulicity and Victoza.	PA	PA	Not Covered
Palynziq	Coverage requires documentation to support the following: 1. Diagnosis of phenylketonuria 2. Age ≥ 18 years old 3. Following a phenylalanine-restricted diet 4. Phenylalanine concetration ≥ 600 umole/liter 5. Trial and failure of Kuvan (Requires prior authorization)	PA	PA	PA
Pennsaid 2%	Coverage requires documentation of the following: 1. Diagnosis of osteoarthritis of the knee. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs. 3. Trial of generic Pennsaid 1.5% topical solution.	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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 requires documentation to support the following: 1. Diagnosis of actinic keratosis 2. Trial and treatment failure of 3 different treatment courses of cryotherapy or phototherapy 3. Trial and treatment failure of two generic or preferred alteranatives which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara) Approve for 3 months Renewal criteria: Documentation of recurrence and/or new lesions Renewal approval: 3 months	ST	ST	ST
Pomalyst*	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
Praluent	Coverage requires attestation to support the following: 1. Diagnosis heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease 2. Prescribed by or in consultation with cardiologist, endocrinologist or board certified lipidologist 3. Trial of one high intensity statin 4. Members with statin intolerance (skeletal muscle related symptoms) must have tried generic Crestor and generic Lipitor OR 5. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)	PA	PA	PA
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Procrit	Coverage requires documentation to support the following: 1. FDA approved indication 2. Hemoblogin less than 10 g/dl Initial approval: 3 months Continued renewal requires documentation of Hgb < 12 g/dl Not covered under pharmacy benefit if on dialysis.	PA	PA	PA
Procysbi	Coverage requires documentation to support the following: 1. Treatment of nephropathic cystinosis 2. Has had a positive reponse to oral cysteamine (Cystagon) but have experienced intolerable side effects	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
Pulmozyme	Coverage requires documentation to support a diagnosis of cystic fibrosis	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Qbrexza	Coverage requires documentation to support the following: 1. Treatment of primary axillary hyperhidrosis 2. Age ≥ 9 years of age 3. Trial of Drysol	PA	PA	Not Covered
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 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
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 will be provided when all of the following have been met: 1. Diagnosis of short ragweed pollen induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen. 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral antihistamine c. Leukotriene receptor antagonist	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Ravicti	Coverage requires documentation to support the following: 1. Diagnosis of urea cycle disorder 2. Trial and treatment failure of dietary protein restriction and/or amino acid supplementation 3. Trial and treatment failure of Buphenyl	PA	PA	PA
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 requires documentation to support the following: Trial of 2 generic triptans (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).	ST	ST	ST

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Repatha	Coverage requires attestation to support the following: 1. Diagnosis of primary hyperlipidemia, heterozygous or homozygous familial hypercholesterolemia or established cardiovascular disease 2. Prescribed by or in consultation with cardiologist, endocrinologist or board certified lipidologist 3. Trial with one high intensity statin 4. Members with statin intolerance (skeletal muscle related symptoms) must have tried generic Crestor and generic Lipitor OR 5. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)	PA	PA	PA
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
Rexulti	Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone), one of which must be generic aripiprazole (Abilify).	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Rhopressa	Coverage requires documentation to support the following: 1. Diagnosis of glaucoma or ocular hypertension. 2. Trial of three preferred medications (examples include Xalatan, Lumigan, timolol)	PA	PA	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
Ruconest	Coverage requires documentation to support the following: 1. Diagnosis of treatment of acute attacks of type 1 or type 2 hereditary angioedema (HAE) 2. Diagnosis of HAE must be confirmed by genetic testing or with all the following laboratory findings: a. Normal C1q levels b. C4 levels below the limits of the laboratory's normal reference range c. C1-INH levels (antigenic or functional) below the limits of the laboratory's normal reference range Or 1. For short-term prophylaxis 2. Treatment failure of an attenuated androgen (such as Danocrine (danazol) or Oxandrin (oxandrolone)	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Rydapt*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Rytary	Coverage requires trial and treatment failure of generic Sinemet CR.	PA	PA	Not Covered
Sabril tablet	Coverage requires documentation to support the following: 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and treatment failure of three generic alternatives for seizure 3. Trial of Sabril powder OR Diagnosis of infantile spasms	ST	ST	ST

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
Sandostatin LAR	Coverage requires documentation to support the following: 1. Diagnosis of acromegaly, carcinoid tumors or vasoactive intestinal peptide tumors(VIPomas). 2. Previously tried, responded and tolerated generic immediate release octreotide	PA	PA	PA
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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 requires documentation to support the following: 1. Treatment of hypercortisolism as a result of endogenous Cushing's syndrome 2. Surgical treatment has not been effective or is not an option 3. Treatment failure or intolerance to ketoconazole or mitotane, unless contraindicated	PA	PA	PA
Signifor LAR	Coverage requires documentation to support the following: 1. Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option 2. Trial of one preferred product used for acromegaly Or Treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative	PA	PA	Not Covered
Siklos	Coverage requires documentation to support the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 2 years old 3. Unable to swallow capsules/tablets	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Silenor	Coverage requires documentation to support the following: 1. Trial and treatment failure or intolerance to generic Ambien (zolpidem) 2. Trial and treatment failure or intolerance to generic Desyrel (trazodone) 3. Trial and treatment failure or intolerance to generic Sinequan (doxepin) 4. Trial and treatment failure or intolerance to generic Sonata (zaleplon)	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Simponi	Coverage requires documentation to support the following: 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Cosentyx, Enbrel or Humira OR 1. Diagnosis of Rheumatoid arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD). Examples include methotrexate, sulfasalazine, azathioprine. 4. Trial and treatment failure to two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR. 5. Using in combination with methotrexate OR 1. Diagnosis of Psoriatic arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one DMARD 4. Trial and treatment failure of two of the following: Cosentyx, Enbrel, Humira OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one immunomodulatory medication. Examples include azathioprine, methotrexate, cyclosporine. 4. Trial and treatment failure of Humira	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Sirturo	Coverage requires documentation to support the following: 1. 18 years of age or older 2. Treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB)	PA	PA	PA
Sitavig	Coverage requires documentation to support the following: Trial and failure of all of the following: 1.Generic oral acyclovir (Zovirax) 2.Generic valacyclovir (Valtrex).	ST	ST	Not Covered
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 requires documentation to support the following: 1. Diagnosis of actinic keratosis 2. Trial and treatment failure of 3 different treatment courses using cryotherapy or phototherapy 3. Trial of 2 topical generic or preferred agents which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara) Approve for 3 months Renewal criteria: Documentation of recurrence and/or new lesions	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
Somatuline Depot	Coverage requires documentation to support the following: Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option. Or Diagnosis of gastroenteropancreatic neuroendocrine tumors OR Diagnosis of carcinoid syndrome	PA	PA	PA
Somavert	Coverage requires documentation to support the following: Diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Soolantra	Coverage requires documentation to support the following: Trial and failure of all of the following: 1. Generic topical metronidazole. 2. Generic topical sulfacetamide 10%-sulfur 5%. 3. Generic oral tetracycline, generic doxycycline or generic minocycline.	ST	ST	Not Covered
Sovaldi	Coverage requires documentation to support the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Trial of preferred medication: Epclusa or Zepatier 4. Documentation of previous treatment experience for Hepatitis C 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier	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
Steglujan	Coverage requires documentation to support the following: 1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated. 2. Trial and treatment failure of Qtern (dapagliflozin/saxagliptin)	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Stelara	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Treatment with phototherapy or photo chemotherapy was ineffective, contraindicated, or not tolerated. 3. Treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated. (Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin). OR 1. Diagnosis of psoriatic arthritis 2. Treatment with one oral systemic agent for psoriatic arthritis was ineffective or not tolerated, unless all are contraindicated. (Examples to systemic agents include, but are not limited to, cyclosporine, methotrexate and lefludomide). OR 1. Crohn's disease: treatment of adult patients with active Crohn's disease 2. Conventional therapy (examples: corticosteroids, immunomodulators) has been ineffective, contraindicated or not tolerated based on clinical documentation	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
Stivarga*	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
Strensiq	Coverage requires documentation to support the following: 1. Diagnosis of perinatal/infantile-and juvenile-onset hypophosphatasia. 2. < 18 years old at onset of symptoms. 3. Diagnosis must be made by or in consultation with a geneticist, metabolic specialist, endocrinologist or bone and mineral specialist	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
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 requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).	ST	ST	Not Covered
Sutent*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Symdeko	Coverage requires documentation to support the following: 1. Age > 12 years old 2. Diagnosis of cystic fibrosis (CF) 3. Presence of two copies of the F508del mutation OR at least one mutation in the CTFR gene that is responsive to Symdeko as confirmed by genetic test 4. Prescribed by a cystic fibrosis expert Initial authorization period: 1 year Renewal requires documentation of improvement in CF symptoms	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Syprine	Coverage requires documentation to support the following: 1. Diagnosis of Wilson's disease 2. Trial of or intolerance to a preferred d- penicillamine product (Depen)	PA	PA	PA
Taclonex topical suspension	Coverage requires documentation to support the following: 1. Trial and treatment failure with a very high potency topical steroid (ex. generic Diprolene ointment, generic Psorcon, or generic Temovate) AND 2. Using in combination with generic Dovonex	PA	PA	PA
Tadalafil (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
Tadalafil (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
Tafinlar*	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
Taltz	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure to light therapy 4. Trial and treatment failure to one generic oral systemic agent (cyclosporine, methotrexate, acitretin) 5. Trial and treatment failure to two of the following: Cosentyx, Enbrel, Humira or Stelara. OR 1. Diagnosis of psoriatic arthritis 2. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD) Examples include methotrexate, sulfasalazine, azathioprine 3. Trial and treatment failure to two of the following: Cosentyx, Enbrel, Humira or 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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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: Byetta, Bydureon/ BudureonBCise, Trulicity and Victoza.	PA	PA	Not Covered
Tarceva*	Coverage is provided for the treatment of the FDA approved indications.	PA	PA	PA
Targretin capsules* (bexarotene)	Coverage requires documentation to support the following: 1. Diagnosis of cutaneous T-cell lymphoma (CTCL) 2. Treatment failure or intolerance to at least one systemic therapy Initial approval: 1 year Renewal: No evidence of disease progression	PA	PA	PA
Targretin gel	Coverage requires documentation to support the following: 1. Diagnosis of Cutaneous T-cell lymphoma 2. Topical treatment of cutaneous lesions	PA	PA	PA
Tasigna*	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
Tavalisse	Coverage requires documentation to support the following: Diagnosis of chronic immunie thrombocytopenia (IT) and persistent thrombocytopenia (platelet count < 100,000mcl) for ≥ 3 months and all of the following: 1. Age ≥ 18 years old 2. Prescribed by or in consultation with a hematologist 3. Trial and treatment failure or not a candidate for treatment with corticorsteroids, immunoglobulins or splenectomy 4. Current plately count is < 20,000 mcl or < 30,000 mcl and symptoms of active bleeding 5. Trial of Promacta	PA	PA	PA
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 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
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 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
Thiola	Coverage provided when all of the following have been met: 1. For the prevention of cystine stone formation in members ≥ 9 years old. 2. Urinary cystine concentration > 500mg/day. 3. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalinization.	PA	PA	PA
Tibsovo	Coverage requires documentation of the following: FDA approved indications	PA	PA	PA
Tivorbex	Coverage requires documentation to support the following: 1. Diagnosis of acute pain 2. Trial and treatment failure of oral indomethacin 3. Trial and treatment failure of two other oral preferred NSAIDs	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Tobi Podhaler	Coverage requires documentation to support the following: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa 2. Trial and failure of generic tobramycin inhalation nebulization solution.	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
Toviaz	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies.	ST	ST	ST
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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Tremfya	Coverage requires documentation to support the following: 1. Diagnosis of psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one oral therapy (examples include methotrexate, cyclosporine, acitretin) 4. Trial and treatment failure to Humira	PA	PA	PA
Treximet	Coverage requires documentation to support the following: 1. Trial of generic sumatriptan (Imitrex) and naproxen used in combination. 2. Trial of a second generic triptan (Maxalt, Amerge)	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 requires documentation to support the following: 1. Treatment osteoporosis 2. Patient has tried and failed or has a contraindication to a generic bisphosphonate (generic Fosamax, generic Boniva or generic Actonel). Tymlos will be approved for a maximum of 2 years	PA	PA	PA
Tyvaso	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
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
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 requires documentation to support the following: 1. Diagnosis of Stage 1A or 1B mycosis fungoides type cutaneous T cell lymphoma 2. Trial of photo therapy or total skin electron beam therapy 3. Trial of carmustine or topical retinoid Initial approval: 1 year Renewal requires documentation of a positive clinical response to treatment.	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
Vascepa	Coverage is provided when all the following criteria are met: 1. Trial of generic gemfibrozil (Lopid). 2. Trial of generic fenofibrate (Tricor, Trilipix, Antara) 3. Trial of generic Lovaza	PA	PA	Not Covered
Vecamyl	Coverage requires a trial with all of the following drug classes: 1. Diuretic 2. Beta-Blocker 3. Ace-inhibitor 4. Angiotensin II receptor blocker 5. Calcium channel blocker	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Venclexta*	Coverage requires documentation to support the following: Treatment of FDA approved indications. Initial approval: 1 year Renewal: Documentation noting absence of disease progression or unacceptable toxicity	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
Vesicare	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies.	ST	ST	ST
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
Viberzi	Coverage requires documentation to support the following: 1. Diagnosis of Irritable Bowel Syndrome with diarrhea (IBS-D) 2. Trial of all of the following: a. Loperamide b. Antispasmodic (ex. Dicyclomine, hyoscyamine) c. Tricyclic antidepressant (ex. nortriptyline)	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Viibryd, dosepak	Requires trial and failure of at least three generic or preferred antidepressant agents	PA	PA	PA
Vivlodex	Coverage will be provided when all of the following have been met: 1. Diagnosis of osteoarthritis 2. Trial and failure of generic meloxicam 3. Trial and failure of two other preferred oral NSAIDs	PA	PA	Not Covered
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 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 requires documentation to support the following: 1. Age 18 years or older 2. For patients with chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection that have failed treatment regimen containing an NS5A (nonstructural protein 5A) inhibitor and have no liver damage or have liver damage and showing no symptoms from the damage. 3. For patients with chronic hepatitis C genotype 1a or 3 that have previously failed sofosbuvir containing regimen without an NS5A inhibitor and have no liver damage or have liver damage and showing symptoms of the damage. 4. Trial and failure to preferred medication: Epclusa or Zepatier 5. Documentation of previous treatments for Hepatitis C 6. Documentation of compensated or decompensated cirrhosis 7. Written by a hepatologist, gastroenterologist, or infectious disease specialist Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Xeljanz	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis in adults 2. Trial and failure of one DMARD (examples of DMARDs include methotrexate, sulfasalazine, azathioprine) OR 1. Diagnosis of psoriatic arthritis 2. Trial and failure of one disease-modifying antirheumatic drug (DMARDs) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine 3. Trial and failure or intolerance to two of the following: Cosentyx, Enbrel, Humira or Stelara OR 1. Diagnosis of ulcerative colitis 2. Trial and treatment failure or intolerance to conventional therapies (corticosteroids, immunomodulator) 3. Trial and treatment failure or intolerance Humira	PA	PA	PA

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Xeljanz XR	Coverage requires documentation to support the following: 1. Diagnosis of rheumatoid arthritis in adults 2. Trial and failure of one DMARD (examples of DMARDs include methotrexate, sulfasalazine, azathioprine) OR 1. Diagnosis of psoriatic arthritis 2. Trial and failure of one disease-modifying antirheumatic drug (DMARDs) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine 3. Trial and failure or intolerance to two of the following: Cosentyx, Enbrel, Humira or Stelara	PA	PA	PA
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
Xepi	Coverage requires documentation to support the following: 1. Diagnosis of impetigo 2. Trial of generic Bactroban	ST	ST	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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	Coverage requires documentation to support the following: 1. Diagnosis of Irritable Bowel Syndrome with diarrhea (IBS-D) 2. Trial of all of the following: a. Loperamide b. Antispasmodic (ex. Dicyclomine, hyoscyamine) c. Tricyclic antidepressant (nortriptyline) or SSRI (Paxil, Zoloft Approval length: 1 month Or 1. Diagnosis of Hepatic encephalopathy 2. Trial of lactulose	PA	PA	PA
Xolegel	Coverage requires documentation to support the following: 1. 12 years of age or older 2. Treatment of seborrheic dermatitis 3. Treatment failure or intolerance to three generic preferred topical agents, one of which must be ketoconazole	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Xuriden	Coverage required documentation to support the following: 1. Diagnosis of Hereditary Orotic Aciduria. 2. Prescribed by or in consultation with an endocrinologist or geneticist.	PA	PA	PA
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
Yonsa	Coverage requires documentation of the following: FDA approved indications	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
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
Zembrace Symtouch	Coverage requires documentation to support the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)).	PA	PA	Not Covered

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
Zepatier	Coverage requires documentation of the following: 1. Age 18 years or older 2. Diagnosis of Chronic Hepatitis C genotype 1 or 4 3. For genotype 1a patients, test results for NS5a resistance-associated polymorphisms 4. Documentation of previous treatment experience for Hepatitis C 5. Documentation of compensated or decompensated cirrhosis 6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.	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
Zipsor	Coverage requires documentation to support the following: 1. Diagnosis of acute pain 2. Trial and failure of oral diclofenac 3. Trial and failure of two other preferred oral NSAIDs	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

Drug Name	HMO Criteria	Comprehensive Drug List	Custom Drug List	Custom Select Drug List
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
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 requires trial and treatment failure or intolerance of two generic triptans. (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT).	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
Zorvolex	Coverage requires documentation to support the following: 1. Requires a diagnosis of acute pain or osteoarthritis. 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional nonsteroidal anti-inflammatory drugs (NSAIDs).	PA	PA	Not Covered
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

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.