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<sup>SM</sup> members can be viewed on our Web site: bcbsm.com.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>HMO Criteria</th>
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<tbody>
<tr>
<td>Abstral</td>
<td>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</td>
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<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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<tr>
<td>Aciphex Sprinkle</td>
<td>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)).</td>
</tr>
<tr>
<td>Actemra</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of rheumatoid arthritis or giant cell arthritis.</td>
</tr>
<tr>
<td>Acthar H.P.</td>
<td>Coverage is provided for the treatment of infantile spasms (West Syndrome).</td>
</tr>
<tr>
<td>Actiq (fentanyl citrate)</td>
<td>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.</td>
</tr>
<tr>
<td>Adcirca</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. Diagnosis of pulmonary arterial hypertension (WHO Group 1).</td>
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<tr>
<td></td>
<td>2. Treatment failure or intolerance to generic Revatio.</td>
</tr>
<tr>
<td>Adderall XR (dextroamphetamine /amphetamine)</td>
<td>Coverage is provided in situations where the member has experienced treatment failure of or intolerance to brand name Adderall XR.</td>
</tr>
<tr>
<td>Addyi</td>
<td>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.</td>
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<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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<tr>
<td>Adempas</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. Diagnosis of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO GROUP 4) after surgical treatment or inoperable CTEPH.</td>
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<tr>
<td></td>
<td>OR</td>
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<tr>
<td></td>
<td>2. Diagnosis of Pulmonary Arterial Hypertension (PAH)(WHO Group 1)</td>
</tr>
<tr>
<td>Adoxa/Adoxa Pak (doxycycline monohydrate)</td>
<td>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).</td>
</tr>
<tr>
<td>Adlyxin</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated.</td>
</tr>
<tr>
<td></td>
<td>2. Trial of all preferred products: Byetta, Bydureon/ BudureonBCise, Trulicity and Victoza.</td>
</tr>
<tr>
<td>Adzenys ER</td>
<td>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)).</td>
</tr>
<tr>
<td>Drug Name</td>
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</tr>
<tr>
<td>Adzenys XR-ODT</td>
<td>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)).</td>
</tr>
<tr>
<td>Afinitor, Disperz*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
</tr>
<tr>
<td>Afrezza</td>
<td>Coverage is provided when the member has experienced treatment failure or intolerance to Novolog</td>
</tr>
<tr>
<td>Aimovig</td>
<td>Coverage requires documentation to support the following:</td>
</tr>
<tr>
<td></td>
<td>1. Age ≥ 18 years old</td>
</tr>
<tr>
<td></td>
<td>2. Being used for preventive treatment of migraine headaches</td>
</tr>
<tr>
<td></td>
<td>3. Member has history of ≥ 4 headache days per month</td>
</tr>
<tr>
<td></td>
<td>4. Trial of two medications from two different classes for the prevention of migraines</td>
</tr>
<tr>
<td>Drug Name</td>
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<td>--------------------</td>
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<tr>
<td>Akynzeo</td>
<td>Coverage will be provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following:</td>
</tr>
<tr>
<td></td>
<td>1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril).</td>
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<tr>
<td></td>
<td>2. Preferred NK1 antagonist (ex. Emend)</td>
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<tr>
<td></td>
<td>3. Glucocorticoid (dexamethasone)</td>
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<tr>
<td></td>
<td>Initial approval 1 year</td>
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<tr>
<td></td>
<td>Renewal requires documentation of continuation of chemotherapy</td>
</tr>
<tr>
<td>Alecensa*</td>
<td>Coverage requires documentation to support the following:</td>
</tr>
<tr>
<td></td>
<td>1. Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer</td>
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<tr>
<td></td>
<td>Initial approval: 1 year</td>
</tr>
<tr>
<td></td>
<td>Continuation of treatment requires documentation of a lack of disease progression or unacceptable toxicity</td>
</tr>
<tr>
<td>Alogliptin</td>
<td>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)).</td>
</tr>
<tr>
<td>Alogliptin-</td>
<td>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.</td>
</tr>
<tr>
<td>metformin</td>
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<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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<tr>
<td>Alogliptin-pioglitazone</td>
<td>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.</td>
</tr>
<tr>
<td>Alunbrig*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
</tr>
</tbody>
</table>
| Ampyra                 | **Initial treatment:** Coverage is provided for the treatment of multiple sclerosis in situations where the member experiences difficulty walking resulting in significant limitations of instrumental activities of daily living and when two timed 25-foot walk (T25FW) measurements that are within 10% variability and demonstrates that the member is able to walk 25 feet in 8-45 seconds are submitted to the plan, and where the member is on current disease-modifying therapy.  

**To continue:** Coverage is provided in situations where the member’s walking speed has improved by at least 20% as assessed by the T25FW AND that limitations of instrumental activities of daily living have improved as a result of increased walking speed within the first 2 months of therapy. Coverage thereafter will be provided if there is documentation that the member has maintained or experienced improved walking speed from the previous measurement, and where the member is on current disease-modifying therapy. | PA                       | PA               | PA                      |
<p>| Amrix                  | Coverage requires previous trial and treatment failure of generic immediate-release cyclobenzaprine (Flexeril).                                                                                                                                                                                                                     | ST                       | ST               | Not Covered             |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 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%          | **Coverage requires documentation of androgen deficiency confirmed by:**  
| (testosterone)       | 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  
<p>|                      | 2. Improvement in signs or symptoms specific to testosterone deficiency                                                                                                                                 | PA                      | PA               | PA                      |</p>
<table>
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<tbody>
<tr>
<td>Androge 1.62%</td>
<td>Coverage requires documentation of androgen deficiency confirmed by: &lt;br&gt; 1. Two morning testosterone levels in the past year below normal range. &lt;br&gt; 2. For BMI &gt; 30, two morning free testosterone levels must be submitted. &lt;br&gt; 3. At least two signs or symptoms specific to testosterone deficiency &lt;br&gt; Renewal criteria: &lt;br&gt; 1. Testosterone levels are at or below normal range &lt;br&gt; 2. Improvement in signs or symptoms specific to testosterone deficiency</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Aplenzin</td>
<td>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).</td>
<td>PA</td>
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<tr>
<td>Aptiom</td>
<td>Coverage requires documentation to support the following: &lt;br&gt; 1. Treatment of seizures in patients with epilepsy &lt;br&gt; 2. Has experienced treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures &lt;br&gt; OR  &lt;br&gt; Currently stable on Apliom for the treatment of seizures</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Drug Name</td>
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<td>Custom Select Drug List</td>
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<td>Aranesp</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. FDA approved indication</td>
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<td></td>
<td>2. Hemoglobin less than 10 g/dl</td>
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<td></td>
<td>3. Trial of preferred agent, Procrit</td>
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<td></td>
<td>Initial approval: 3 months</td>
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<td>Continued renewal requires documentation of Hgb &lt; 12 g/dl</td>
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<td></td>
<td>Not covered under pharmacy benefit if on dialysis</td>
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<tr>
<td>Arcalyst*</td>
<td>Coverage is provided for the treatment of cryopyrin-associated periodic syndrome in members 12 years of age or older.</td>
<td>PA</td>
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<tr>
<td>Arimidex*</td>
<td>PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>(anastrozole)</td>
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<tr>
<td>Aromasin*</td>
<td>PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>(exemestane)</td>
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<tr>
<td>Atelvia</td>
<td>Coverage requires documentation to support trial and treatment failure or intolerance to two of the following:</td>
<td>ST</td>
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<td>ST</td>
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<tr>
<td>(risedronate)</td>
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</tr>
<tr>
<td></td>
<td>1. Actonel (risedronate)</td>
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<td></td>
<td>2. Boniva (ibandronate) or</td>
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<td></td>
<td>3. Fosamax (alendronate)</td>
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<tr>
<td>Drug Name</td>
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<tr>
<td>Austedo</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
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<td>PA</td>
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<tr>
<td></td>
<td>1. Diagnosis of chorea associated with Huntington's disease</td>
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<td>Or</td>
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<td></td>
<td>2. Diagnosis of Tardive Dyskinesia</td>
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<tr>
<td>Axert</td>
<td>Requires trial of 2 generic triptans: (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT)</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
</tr>
<tr>
<td>Axiron (testosterone)</td>
<td>Coverage requires documentation of androgen deficiency confirmed by:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>1. Two morning testosterone levels in the past year below normal range.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2. For BMI &gt; 30, two morning free testosterone levels must be submitted.</td>
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<tr>
<td></td>
<td>3. At least two signs or symptoms specific to testosterone deficiency</td>
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</tr>
<tr>
<td></td>
<td>4. Trial and treatment failure or intolerance to Androgel and Androderm</td>
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<tr>
<td></td>
<td>Renewal criteria:</td>
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</tr>
<tr>
<td></td>
<td>1. Testosterone levels are at or below normal range</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Improvement in signs or symptoms specific to testosterone deficiency</td>
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<tr>
<td>Beconase AQ</td>
<td>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).</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Drug Name</td>
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<tr>
<td>Belbuca</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Belsomra</td>
<td>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).</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Belviq, XR</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
| 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 |
<table>
<thead>
<tr>
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</thead>
</table>
| 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 |
<p>| 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 |</p>
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Brisdelle (paroxetine mesylate)</td>
<td>Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Effexor (venlafaxine) and Paxil (paroxetine hcl).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Briviact</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Bystolic</td>
<td>Coverage requires documentation to support the following: 1. Trial and treatment failure to at least two preferred cardioselective beta-blockers such as atenolol (Tenormin), metoprolol (Toprol/XL), bisoprolol (Zebeta), betaxolol (Kerlone)</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
</tr>
<tr>
<td>Cabometyx*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
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<tr>
<td>Calquence*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Caprelsa*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Carbaglu</td>
<td>Coverage is provided for the treatment of hyperammonemia due to a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) as confirmed by enzyme or DNA mutation analysis.</td>
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<td>Drug Name</td>
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<tr>
<td>Cayston</td>
<td>Coverage is provided for the treatment of Pseudomonas aeruginosa infection in members with cystic fibrosis.</td>
<td>PA</td>
<td>PA</td>
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</tr>
</tbody>
</table>
| 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 |
| 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 |
<p>| Cholbam   | Coverage is provided for the treatment of bile acid synthesis disorders due to single enzyme defects (SEDs) or peroxisomal disorders (PDs) (including Zellweger spectrum disorders) with manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption. | PA | PA | PA |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Chorionic Gonadotropin</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Cialis</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Cialis 2.5 mg, 5 mg</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Drug Name</td>
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<tr>
<td>Cimzia syringe</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of:</td>
<td>PA</td>
<td>PA</td>
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<td></td>
<td>• <strong>Ankylosing spondylitis</strong> in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Cosentyx, Enbrel, or Humira.</td>
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<td>• <strong>Crohn’s disease</strong> in situations where the member has experienced treatment failure of or intolerance to an adequate course of systemic corticosteroids or immunomodulatory medication for at least 2 months and Humira.</td>
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<td></td>
<td>• <strong>Moderate to severe rheumatoid arthritis</strong> in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of one nonbiologic disease modifying anti-rheumatic drug (DMARD) and TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR.</td>
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<td></td>
<td>• <strong>Psoriatic arthritis</strong> in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of one nonbiologic disease modifying anti-rheumatic drug (DMARD) and TWO of the following: Cosentyx, Enbrel, Humira, or Stelara.</td>
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<tr>
<td></td>
<td>• <strong>Diagnosis of psoriasis</strong> Trial and treatment failure of phototherapy, Trial and treatment failure of a generic oral systemic agent (cyclosporine, methotrexate, acitretin), Trial and treatment failure to two of the following: Cosentyx, Humira, Otezla or Stelara</td>
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<tr>
<td>Cometriq*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>PA</td>
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<td>Drug Name</td>
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<tr>
<td>Compounds</td>
<td>Coverage criteria include all the below:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td></td>
<td>• The compound is medically necessary for the member’s condition.</td>
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<td></td>
<td>• The compound contains only FDA approved medications.</td>
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<td></td>
<td>• There are no appropriate FDA approved commercial formulations of the compound available.</td>
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<td><strong>Note:</strong> U6Ws (bulk powders) are not covered.</td>
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<tr>
<td>Contrave ER</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td>Maximum benefit is limited to 12 months of treatment.</td>
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<tr>
<td>Corlanor</td>
<td>Coverage is provided for members with heart failure and a left ventricular ejection fraction ≤ 35% in situations where the member is currently stable on a maximally tolerated dose of a beta-blocker (such as Toprol XL (metoprolol)) or has a documented contraindication to beta-blocker use. Coverage is not provided for use in combination with Entresto.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td><strong>Cosentyx</strong></td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td><strong>Cotellic</strong></td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>PA</td>
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<td>Drug Name</td>
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<tr>
<td>Crinone 8%</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Cuvitru</td>
<td>Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td>Cycloset</td>
<td>Coverage is provided in members who have experienced treatment failure or intolerance to at least 2 generic oral diabetes drugs.</td>
<td>ST</td>
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<tr>
<td>Cystaran</td>
<td>Coverage is provided for members with a diagnosis of cystinosis who are also taking oral cysteamine (such as Cystagon).</td>
<td>PA</td>
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<tr>
<td>Daklinza</td>
<td>Coverage requires documentation to support the following:</td>
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<td>PA</td>
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<td></td>
<td>1. Age 18 years or older</td>
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<td></td>
<td>2. Prescribed in conjunction with Sovaldi for the treatment of chronic hepatitis C genotype 1 or 3</td>
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<td>3. Documentation of previous treatment experience for Hepatitis C</td>
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<td>4. Documentation of compensated or decompensated cirrhosis</td>
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<td>5. Prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.</td>
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<td>6. Trial of preferred medication: Epclusa or Zepater</td>
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<td>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 Zepater.</td>
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<tr>
<td>Daliresp</td>
<td>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).</td>
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<tr>
<td>Daraprim</td>
<td>Coverage is provided for malaria chemoprophylaxis and the treatment of malaria or toxoplasmosis.</td>
<td>PA</td>
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</tr>
<tr>
<td>Desvenlafaxine ER</td>
<td>Requires trial and failure of at least three generic or preferred antidepressant agents</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dexilant</td>
<td>Coverage is provided in situations where the member has experienced treatment failure of or intolerance to all of the following: Aciphex (rabeprazole), Prilosec (omeprazole) or Prilosec OTC, AND Protonix (pantoprazole), one of which is at a twice daily, high dose regimen.</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dibenzyline</td>
<td>Coverage is provided for the treatment of hypertension and sweating episodes due to pheochromocytoma:</td>
<td>PA</td>
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<td>(phenoxybenzamine hcl)</td>
<td><strong>Preoperative treatment:</strong> 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.</td>
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<td><strong>Non-preoperative treatment:</strong> 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)).</td>
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<tr>
<td>Diclegis</td>
<td>Coverage is provided when the member has experienced treatment failure to the use of the individual agents (doxylamine and pyridoxine) in combination.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Doptelet</td>
<td>Coverage requires documentation to support the following:</td>
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<td></td>
<td>1. Age ≥ 18 years old</td>
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<td>2. Diagnosis of thrombocytopenia in chronic liver disease</td>
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<td>3. Platelet count &lt; 50,000 mcL</td>
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<td>4. Scheduled to undergo a procedure</td>
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<td>Approval: 1 month</td>
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<tr>
<td>Doryx/Doryx MPC</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td></td>
<td>Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin).</td>
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<tr>
<td>Doxepin topical cream</td>
<td>Coverage requires documentation to support the following:&lt;br&gt;1. Diagnosis of atopic pruritic or lichen simplex chronicus&lt;br&gt;2. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product&lt;br&gt;3. Trial and treatment failure to one preferred topical calcineurin inhibitor (tacrolimus, pimecrolimus)&lt;br&gt;OR&lt;br&gt;1. Diagnosis of peripheral neuropathic pain&lt;br&gt;2. Trial and treatment failure of two over-the-counter topical analgesics&lt;br&gt;3. Trial and treatment failure of one preferred topical non-steroidal anti-inflammatory drug (NSAID)&lt;br&gt;Approve for 1 month</td>
<td>PA</td>
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<tr>
<td>Duopa</td>
<td>Coverage requires documentation to support the following:&lt;br&gt;1. Diagnosis of advanced Parkinson’s disease&lt;br&gt;2. Member has a feeding tube</td>
<td>PA</td>
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<tr>
<td>Dupixent</td>
<td>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).</td>
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<tr>
<td>Duzallo</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dyanavel XR</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td>Dymista</td>
<td>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.</td>
<td>PA</td>
<td>Not Covered</td>
<td>Not Covered</td>
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</tbody>
</table>
| 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           |
<p>| Edarbi    | Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB)                                                                 | ST                      | ST               | ST                    |
| Edarbyclor| Requires documentation that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blocker (ARB)                                                                 | ST                      | ST               | ST                    |
| Edluar    | Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Ambien CR (zolpidem) and either Lunesta (eszopiclone) or Sonata (zaleplon).                                      | ST                      | ST               | Not Covered           |
| Egrifta   | Coverage is provided for members 18 years of age or older for the treatment of excess abdominal fat in HIV-associated lipodystrophy who are receiving antiretroviral therapy.                                              | PA                      | PA               | Not Covered           |</p>
<table>
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<tr>
<td>Embeda</td>
<td>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).&lt;br&gt;&lt;br&gt;&lt;strong&gt;Note:&lt;/strong&gt; Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.</td>
<td>PA</td>
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<tr>
<td>Emflaza</td>
<td>Coverage is provided for members 5 years of age or older for the treatment of Duchenne’s Muscular Dystrophy in situations where the member has experienced treatment failure of or intolerance to prednisone or prednisolone.</td>
<td>PA</td>
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<tr>
<td>Enbrel</td>
<td>Coverage is provided for the treatment of ankylosing spondylitis, pediatric psoriasis, polyarticular juvenile idiopathic arthritis, psoriatic arthritis, and rheumatoid arthritis. Coverage is provided for the treatment of moderate to severe plaque psoriasis in situations where the member has experienced treatment failure of or intolerance to Humira.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Endari</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Endometrin</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td>Custom Select Drug List</td>
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</table>
| 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                     |
| 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            |
<table>
<thead>
<tr>
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</table>
| Epogen    | Coverage requires documentation to support the following:  
1. FDA approved indication  
2. Hemoglobin 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 |
| 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 |
<table>
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<tbody>
<tr>
<td>Evekeo</td>
<td>Coverage will be provided when one of the following have been met. (A, B or C):</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>A. Narcolepsy:</td>
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<tr>
<td></td>
<td>1. ≥ 6 years of age,</td>
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<td></td>
<td>2. Trial of generic Adderall IR and a generic methylphenidate.</td>
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<td>B. ADHD: (Attention hyperactivity deficit disorder)</td>
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<tr>
<td></td>
<td>1. 3-6 years of age.</td>
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<tr>
<td></td>
<td>i. Trial of an amphetamine or</td>
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<td></td>
<td>2. ≥6rs old,</td>
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<tr>
<td></td>
<td>i. Trial of an amphetamine and a methylphenidate product.</td>
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<td>C. Obesity:</td>
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<td>1. ≥ 12 years of age,</td>
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<td></td>
<td>2. Documentation of BMI &gt; 30 kg/m2,</td>
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<td></td>
<td>3. Documentation of lifestyle modifications, and</td>
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<td></td>
<td>4. Documentation of previous failed weight loss therapies.</td>
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<tr>
<td>Evista* (raloxifene)</td>
<td>Coverage for $0 copayment will be provided when:</td>
<td>PA</td>
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<td></td>
<td>1. The member is a woman at least 35 years of age and post-menopausal.</td>
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<td></td>
<td>2. The medication is being used for prevention of primary breast cancer in members classified as high risk.</td>
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<td></td>
<td>Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE).</td>
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</table>
| 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       |
<table>
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<tr>
<td>Fanapt</td>
<td>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)).</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
</tr>
<tr>
<td>Farydak*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Fazaclo 150, 200 mg</td>
<td>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.</td>
<td>ST</td>
<td>ST</td>
<td>ST</td>
</tr>
<tr>
<td>Femara* (letrozole)</td>
<td>PA required for males: Coverage is provided for the treatment of ER-positive breast cancer.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Fenoprofen calcium (Nalfon, Fenortho, Profeno)</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td></td>
<td>1. Age ≥18 years old</td>
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<td></td>
<td>2. Treatment of mild to moderate pain</td>
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<tr>
<td>Fentora</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ferriprox</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
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<tr>
<td>Fetzima</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Finacea Foam</td>
<td>Coverage will be provided when all of the following have been met:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<td></td>
<td>Trial of all of the following:</td>
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<tr>
<td></td>
<td>1. Generic topical metronidazole</td>
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<td>2. Generic topical sulfacetamide 10%-sulfur 5%</td>
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<td>3. Generic oral tetracycline, generic doxycycline or generic minocycline</td>
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<tr>
<td>Fioricet 50/300/40 mg</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>(butalbital/acetaminophen/caffeine)</td>
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<tr>
<td>Fioricet w/codeine 50/300/30 mg</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>(butalbital/acetaminophen/caffeine/codeine)</td>
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<tr>
<td>Drug Name</td>
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<tr>
<td><strong>Firazyr</strong></td>
<td>Coverage requires documentation to support the following:</td>
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<td>PA</td>
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<tr>
<td></td>
<td>1. Diagnosis of type 1 or type 2 hereditary angioedema (HAE) as confirmed by genetic testing or with all the following laboratory findings:</td>
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<tr>
<td></td>
<td>a. Normal C1q levels</td>
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<td></td>
<td>b. C4 levels below the limits of the laboratory’s normal reference</td>
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<tr>
<td></td>
<td>c. C1-INH levels (antigenic or functional) below the limits of the laboratory’s normal reference range</td>
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<tr>
<td><strong>Flector Patch</strong></td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Diagnosis of acute pain due to minor strains, sprains or contusions.</td>
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<td></td>
<td>2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs.</td>
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<tr>
<td><strong>Follistim AQ</strong></td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Drug Name</td>
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<tr>
<td>Forteo</td>
<td>Coverage requires documentation to support the following:</td>
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<td></td>
<td>1. Treatment of osteoporosis</td>
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<td>2. Trial and failure or contraindication to an oral generic bisphosphonate (generic Fosamax, generic Boniva, generic Actonel)</td>
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<td>Forteo will be approved for a maximum of two years.</td>
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<tr>
<td>Fortesta, Testosterone (Brand) 2% pump</td>
<td>Coverage requires documentation of androgen deficiency confirmed by:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Two morning testosterone levels in the past year below normal range.</td>
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<td>2. For BMI &gt; 30, two morning free testosterone levels must be submitted.</td>
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<td>3. At least two signs or symptoms specific to testosterone deficiency</td>
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<td>4. Trial and treatment failure or intolerance to Androgel and Androderm</td>
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<td></td>
<td>Renewal criteria:</td>
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<tr>
<td></td>
<td>1. Testosterone levels are at or below normal range</td>
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<td></td>
<td>2. Improvement in signs or symptoms specific to testosterone deficiency</td>
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<tr>
<td>Fosamax Plus D</td>
<td>Coverage requires documentation to support trial and treatment failure or intolerance to two of the following:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<td></td>
<td>1. Actonel (risedronate)</td>
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<td></td>
<td>2. Boniva (ibandronate) or</td>
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<td></td>
<td>3. Fosamax (alendronate)</td>
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</table>
| 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                     |
<p>| 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                     |</p>
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<tbody>
<tr>
<td>Gamunex-C sub-q</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Ganirelix Acetate</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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</table>
| 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                      |
<p>| Gelnique        | Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies                                                                                               | ST                      | ST                | Not Covered             |</p>
<table>
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</table>
| 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 |
<p>|<strong>Gilotrif</strong> | Coverage is provided for the treatment of the FDA approved indications. | PA | PA | PA |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
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<tbody>
<tr>
<td>Glassia</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Glyxambi</td>
<td>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)</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Gonal-F, RFF, Redi-ject</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
<td>Comprehensive Drug List</td>
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<td>Custom Select Drug List</td>
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</table>
| 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 |
<table>
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<tr>
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<th>Custom Drug List</th>
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</table>
| 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 |
<table>
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<tr>
<th>Drug Name</th>
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<th>Custom Drug List</th>
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</tr>
</thead>
</table>
| 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 |
<p>| 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 |</p>
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<tr>
<td>Horizant</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>1. Diagnosis of Restless Leg Syndrome (RLS)</td>
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<td></td>
<td>2. Trial and treatment failure of generic Mirapex (pramipexole)</td>
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<td></td>
<td>3. Trial and treatment failure of generic Requip/XL (ropinirole)</td>
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<td>4. Trial and treatment failure of generic Neurontin (gabapentin)</td>
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<td>Or</td>
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<td></td>
<td>1. Diagnosis of post-herpetic neuralgia (PHN)</td>
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<td></td>
<td>2. ≤ 65 years of age</td>
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<td>3. Trial of generic Neurontin (gabapentin)</td>
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<td></td>
<td>4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine)</td>
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<td></td>
<td>Or</td>
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<tr>
<td></td>
<td>1. Diagnosis of post-herpetic neuralgia</td>
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<td></td>
<td>2. ≥ 65 years of age</td>
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<tr>
<td></td>
<td>3. Trial of generic Neurontin (gabapentin)</td>
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<tr>
<td><strong>Humira</strong></td>
<td>Coverage requires documentation of the following:</td>
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<td></td>
<td>1. <strong>Rheumatoid arthritis, juvenile idiopathic arthritis or psoriatic arthritis</strong>: 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).</td>
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<tr>
<td></td>
<td>2. <strong>Ankylosing spondylitis</strong></td>
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<td>3. <strong>Moderate to severe psoriasis</strong>: Requires 3 months of previous treatment with topical corticosteroids and 3 months treatment with phototherapy or photo chemotherapy (unless contraindicated) and therapy must be supervised by a Dermatologist.</td>
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<td>4. <strong>Crohn’s Disease</strong>: 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.</td>
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<td>5. <strong>Ulcerative Colitis</strong>: 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.</td>
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<td>6. <strong>Hiradenitis suppurativa</strong>: Coverage for patients 18 years and older, prescribed by or in consultation with a dermatologist and requires a 3 month trial of oral antibiotics.</td>
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<td>7. <strong>Uveitis</strong>:</td>
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<tr>
<td></td>
<td>a. ≥ 18 years old</td>
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<td>b. Diagnosis of non-infectious intermediate uveitis, posterior uveitis or panuveitis.</td>
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<td></td>
<td>c. Prescribed by ophthalmologist or rheumatologist</td>
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<td></td>
<td>d. Trial of an oral corticosteroid</td>
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<td></td>
<td>e. Trial of an oral immunomodulatory agent. Examples include: methotrexate, azathioprine, cyclosporine.</td>
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<th>Comprehensive Drug List</th>
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<td>PA</td>
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</table>
| 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                    |
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<tr>
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<tbody>
<tr>
<td>HyQvia</td>
<td>Coverage is provided for the treatment of primary humoral immunodeficiency when clinical criteria is met.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Hysingla ER</td>
<td>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). <strong>Note:</strong> Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ibrance*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
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</tr>
<tr>
<td>Iclusig*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Idhifa*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
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<tr>
<td>Imbruvica*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
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</tbody>
</table>
| 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 |
<table>
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<tr>
<td>Ingrezza</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of tardative dyskinesia when prescribed by a psychiatrist or neurologist.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Inlyta*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Intermezzo (zolpidem tartrate)</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Intermezzo (zolpidem tartrate)</td>
<td>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).</td>
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<tr>
<td>Intermezzo (zolpidem tartrate)</td>
<td>Coverage will not be approved for combination therapy with other sedative hypnotics.</td>
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<tr>
<td>Iressa*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Isotretinoin (13-cis-Retinoic Acid)</td>
<td>Amnesteem Claravis Myorisan Zenatane</td>
<td>NA</td>
<td>NA</td>
<td>PA</td>
</tr>
<tr>
<td>Isotretinoin (13-cis-Retinoic Acid)</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td>Isotretinoin (13-cis-Retinoic Acid)</td>
<td>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</td>
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<tr>
<td>Drug Name</td>
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</table>
| 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                      |
<p>| 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            |</p>
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<tr>
<td>Juxtapid</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Diagnosis of homozygous familial hypercholesterolemia (HoFH)</td>
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<td>2. Receiving optimal adjunctive therapies including a low fat diet and other lipid lowering treatments</td>
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<td></td>
<td>3. Trial and treatment failure of Repatha</td>
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<tr>
<td>Kalydeco</td>
<td>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.</td>
<td>PA</td>
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<td>PA</td>
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<tr>
<td>Karbinal ER</td>
<td>Coverage requires trial and treatment failure to generic carbinoxamine and two other generic antihistamines</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Kazano</td>
<td>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.</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Keveyis</td>
<td>Coverage is provided for the treatment of hyperkalemic or hypokalemic periodic paralysis as confirmed by genetic testing or positive family history in members who have experienced treatment failure of lifestyle modifications (such as dietary and exercise alterations) AND Diamox (acetazolamide).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Kevzara</td>
<td>Coverage is provided for the treatment of rheumatoid arthritis when the prescription is written by a rheumatologist in situations where the member has experienced treatment failure of or intolerance to one disease modifying anti-rheumatic drug (DMARD), such as methotrexate, and at least TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Khedezla</td>
<td>Requires trial and failure of at least three generic or preferred antidepressant agents</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td>Drug Name</td>
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<tr>
<td>Kineret</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of rheumatoid arthritis in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Kisqali, Kisqali-Femara co-pack*</td>
<td>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</td>
<td>PA</td>
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<tr>
<td>Korlym</td>
<td>Coverage is provided for members 18 years of age or older with Cushing’s syndrome for the treatment of the following: • <strong>Diabetes mellitus:</strong> in situations where the member has experienced treatment failure of or intolerance to ALL of the following: surgery or radiotherapy, at least 3 months of insulin therapy, and a steroidogenesis inhibitor (such as Nizoral (ketoconazole)). A hemoglobin A1c level within the past year must also be submitted. • <strong>Glucose intolerance:</strong> Coverage is provided secondary to hypercortisolism in situations where the member has experienced treatment failure of or intolerance to surgery or radiotherapy AND a steroidogenesis inhibitor (such as Nizoral (ketoconazole)). A 2-h oral glucose tolerance test (OGTT) within the past year must also be submitted. Initial approval duration: up to 6 months. The member must demonstrate clinically significant improvement in glucose control for continuation of therapy.</td>
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| 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 |
<table>
<thead>
<tr>
<th>Drug Name</th>
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<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
<th>Custom Select Drug List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Livalo</td>
<td>Coverage is provided in situations where the member has experienced treatment failure of or intolerance to two generic statins, <strong>one</strong> of which must be high dose (≥ 40 mg) Lipitor (atorvastatin).</td>
<td>ST</td>
<td>ST</td>
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</tr>
</tbody>
</table>
| Lokelma   | Coverage requires documentation to support the following:  
1. Treatment of hyperkalemia  
2. Trial and treatment failure of a thiazide or loop diuretic 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 |
<p>| Lynparza* | Coverage is provided for the treatment of the FDA approved indications. | PA | PA | PA |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Lyrica</td>
<td><strong>Seizure disorder:</strong> Coverage is provided in situations where the member is being treated concurrently with other anticonvulsants.</td>
<td>PA</td>
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<td></td>
<td><strong>Neuropathic pain:</strong> 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)).</td>
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<td></td>
<td><strong>Fibromyalgia:</strong> 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).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lyrica CR</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
|            | 1. Diagnosis of diabetic neuropathic pain or post-herpetic 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 tricyclic antidepressant, such as amitriptyline, desipramine or imipramine.  
2. Trial and failure of immediate release Lyrica | PA                       | PA               | Not Covered            |
<table>
<thead>
<tr>
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<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
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</tr>
</thead>
</table>
| 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 |
<p>| 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 |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Menopur</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mirapex ER (pramipexole di-hcl)</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
| 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           |
<table>
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<tr>
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</thead>
</table>
| 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 |
| Midulti | 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 |
<p>| 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 |
| Myrbetiq | 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 |</p>
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<tr>
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<tr>
<td>Naftin, gel</td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Namenda XR</td>
<td>Coverage requires documentation to support the following: Trial of generic memantine immediate release (Namenda IR).</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<tr>
<td>Namzaric</td>
<td>Coverage requires documentation to support the following: Already stable on memantine (Namenda) and donepezil (Aricept).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Nasonex (mometasone furoate)</td>
<td>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).</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Natesto</td>
<td>Coverage requires documentation of androgen deficiency confirmed by: 1. Two morning testosterone levels in the past year below normal range. 2. For BMI &gt; 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</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<tr>
<td>Natpara</td>
<td>Coverage is provided for the treatment of hypocalcemia associated with documented hypoparathyroidism in situations where the member is currently being treated with both calcium and Rocaltrol (calcitriol) and is not well controlled.</td>
<td>PA</td>
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<tr>
<td>Nerlynx*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Nesina</td>
<td>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.</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
| 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). |
<p>| Nexavar*          | Coverage is provided for the treatment of the FDA approved indications.                                                                                                                                       | PA                      | PA               | Not Covered            |
| 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                     |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Ninlaro*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Nityr</td>
<td>Coverage requires documentation of the following:</td>
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<td>1. Diagnosis of hereditary tyrosinemia type 1</td>
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<td></td>
<td>2. Using along with dietary restriction of tyrosine and phenylalanine</td>
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<tr>
<td>Noctiva</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>1. Diagnosis of nocturnal polyuria</td>
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<td></td>
<td>2. Age ≥ 50 years old</td>
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<td>3. Lifestyle changes have been tried (including limiting fluids such as water, alcohol and caffeine, elevation of legs)</td>
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<td>4. Treatment failure or intolerance to one generic medication for over active bladder (OAB) (examples tolterodine, oxybutynin)</td>
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<td></td>
<td>5. Trial of generic oral desmopressin</td>
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<td>Drug Name</td>
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</tbody>
</table>
| Norditropin     | **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                        |
<table>
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<tr>
<th>Drug Name</th>
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<tbody>
<tr>
<td>Northera</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of symptomatic neurogenic orthostatic hypotension in situations where the member has experienced treatment failure of or intolerance to Florinef (fludrocortisone) AND Proamatine (midodrine).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Novarel</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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</tbody>
</table>
| 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                     |
<table>
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<tr>
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<tbody>
<tr>
<td>Nucynta ER</td>
<td>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 &lt; 65 years: Neurontin (gabapentin), a tricyclic antidepressant (such as Elavil (amitriptyline)) and Cymbalta (duloxetine).  - Member &gt; 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.</td>
<td>PA</td>
<td>PA</td>
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</tr>
<tr>
<td>Nuedexta</td>
<td>Coverage is provided for the treatment of pseudobulbar affect (PBA) due to a documented underlying neurological condition (such as multiple sclerosis or stroke).</td>
<td>PA</td>
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<tr>
<td>Nuplazid</td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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</tbody>
</table>
### Drug Name: 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.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Ocaliva</td>
<td>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 &lt; ULN at 12 months).</td>
<td>PA</td>
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<tr>
<td>Odactra</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>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.</td>
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<td>2. Trial of one agent from each of the following classes:</td>
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<tr>
<td></td>
<td>a. Intranasal corticosteroid</td>
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<tr>
<td></td>
<td>b. Oral antihistamine</td>
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<td></td>
<td>c. Leukotriene receptor antagonist</td>
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<tr>
<td>Odomzo*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Ofev</td>
<td>Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF).</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Olumiant</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td></td>
<td>1. Diagnosis of Rheumatoid Arthritis</td>
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<td></td>
<td>2. Trial and treatment failure of an oral DMARD</td>
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<td>3. Trial and treatment failure of two of the following: Actemra, Enbrel, Humira or Xeljanz/Xeljanz XR</td>
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<tr>
<td>Omnaris</td>
<td>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).</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
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| 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 |
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>HMO Criteria</th>
<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
<th>Custom Select Drug List</th>
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</thead>
<tbody>
<tr>
<td>Onfi</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Onzeta Xsail</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Opana ER</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Opsumit</td>
<td>Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Oracea</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td>Oralair</td>
<td>Coverage will be provided when all of the following criteria has been met:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>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.</td>
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<td></td>
<td>2. Trial of one agent from each of the following classes:</td>
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<td></td>
<td>a. Intranasal corticosteroid</td>
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<td></td>
<td>b. Oral antihistamine</td>
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<td></td>
<td>c. Leukotriene receptor antagonist</td>
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<tr>
<td>Orencia, Clickject, sub-q</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. Age 18 years and older</td>
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<td></td>
<td>2. Rheumatoid arthritis and when patient has tried a three month trial of Disease Modifying Anti-Rheumatic Drug (DMARD) (examples of DMARDs include methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine) and failed TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR</td>
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<td></td>
<td>3. Psoriatic arthritis when patient has tried a three month trial of DMARD and failed TWO of the following: Cosentyx, Enbrel, Humira, or Stelara.</td>
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<td></td>
<td>OR</td>
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<td></td>
<td>1. Two years or older</td>
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<td></td>
<td>2. Juvenile idiopathic arthritis (JIA) and when patient has tried a three month trial DMARD</td>
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<td></td>
<td>3. Trial and treatment failure of Enbrel and Humira.</td>
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<tr>
<td>Orenitram ER</td>
<td>Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).</td>
<td>PA</td>
<td>PA</td>
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</tr>
</tbody>
</table>
| 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 is provided for the treatment of cystic fibrosis in members 6 years of age or older in situations where the member has confirmed two copies of the F508del mutation in the CFTR gene AND where genetic testing results are submitted to the plan. In addition, the member must have a baseline FEV1 predicted of 30% or greater and must be receiving other chronic maintenance treatment (such as hypertonic saline or dornase alfa). | PA                      | PA              | PA                     |
| 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                     |
<p>| 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            |</p>
<table>
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<tbody>
<tr>
<td>Otezla</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis. Coverage is provided for members 18 years of age or older for the treatment of psoriatic arthritis in situations where the member has experienced treatment failure of or intolerance to ONE of the following: Cosentyx, Enbrel, Humira, or Stelara.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Otrexup</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ovidrel</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Oxiconazole (Oxistat)</td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td>Oxtellar XR</td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Oxycodone hcl ER</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Oxycontin</td>
<td>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.</td>
<td>PA</td>
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<tr>
<td>Ozempic</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td></td>
<td>1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated.</td>
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<td></td>
<td>2. Trial of all preferred products: Byetta, Bydureon/ BudureonBCise, Trulicity and Victoza.</td>
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<tr>
<td>Palynziq</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
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<td></td>
<td>1. Diagnosis of phenylketonuria</td>
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<td>2. Age ≥ 18 years old</td>
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<td>3. Following a phenylalanine-restricted diet</td>
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<td>4. Phenylalanine concentration ≥ 600 umole/liter</td>
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<td>5. Trial and failure of Kuvan (Requires prior authorization)</td>
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<tr>
<td>Pennsaid 2%</td>
<td>Coverage requires documentation of the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>1. Diagnosis of osteoarthritis of the knee.</td>
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<td></td>
<td>2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs.</td>
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<td>3. Trial of generic Pennsaid 1.5% topical solution.</td>
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<tr>
<td>Pexeva</td>
<td>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).</td>
<td>PA</td>
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</table>
| 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 |
| 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 |
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<tbody>
<tr>
<td>Pregnyl</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Prestalia</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prevacid Solutab</td>
<td>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)).</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prilosec suspension</td>
<td>Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Prevacid Solutab.</td>
<td>PA</td>
<td>Not Covered</td>
<td>Not Covered</td>
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</table>
| Procrit            | Coverage requires documentation to support the following:  
  1. FDA approved indication  
  2. Hemoglobin 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                     |
<p>| Procysbi           | Coverage is provided for the treatment of nephropathic cystinosis in situations where the member has experienced treatment failure of or intolerance to Cystagon and a credible explanation as to why Procysbi is expected to work when Cystagon did not is submitted to the plan. | PA                      | PA               | Not Covered            |
| Promacta           | Coverage is provided for treatment of FDA approved indications in situations where the member’s current platelet count is submitted to the plan and when the member has failed other therapies (e.g. corticosteroids). Continued coverage is approved for members with a current platelet count less than 400,000/mcL. | PA                      | PA               | PA                     |
| Protonix suspension| Coverage is provided in situations where the member has experienced treatment failure of or intolerance to Prevacid Solutab.                                                                                                                                                  | PA                      | Not Covered      | Not Covered            |
| Pulmozyme          | Coverage requires documentation to support a diagnosis of cystic fibrosis                                                                                                                                                                                                  | PA                      | PA               | PA                     |</p>
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</table>
| 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 |
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</table>
| 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            |
<p>| 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            |</p>
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<tbody>
<tr>
<td>Quillivant XR</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
| 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          |
<p>| 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          |</p>
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<tr>
<td>Ravicti</td>
<td>Coverage is provided for the treatment of any chronic urea cycle disorder (except for NAGS deficiency) in situations where the member has experienced treatment failure of or intolerance to Buphenyl.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Rayos</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
| 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                     |
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>HMO Criteria</th>
<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
<th>Custom Select Drug List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repatha</td>
<td>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)</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Revatio (sildenafil citrate)</td>
<td>Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1).</td>
<td>N/A</td>
<td>N/A</td>
<td>PA</td>
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<tr>
<td>Revatio suspension</td>
<td>Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) when the member is unable to swallow tablets/capsules.</td>
<td>PA</td>
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<tr>
<td>Rexulti</td>
<td>Requires a trial of two generic antipsychotics (aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone), one of which must be generic aripiprazole (Abilify).</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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</table>
| 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 |
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<thead>
<tr>
<th>Drug Name</th>
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<tbody>
<tr>
<td>Rydapt*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Rytary</td>
<td>Coverage requires trial and treatment failure of generic Sinemet CR.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Sabril tablet</td>
<td>Coverage requires documentation to support the following:</td>
<td>ST</td>
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<tr>
<td></td>
<td>1. Treatment of seizure disorder/epilepsy as adjunctive therapy</td>
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<td></td>
<td>2. Trial and treatment failure of three generic alternatives for seizure</td>
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<td></td>
<td>3. Trial of Sabril powder</td>
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<td></td>
<td>OR</td>
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<tr>
<td></td>
<td>Diagnosis of infantile spasms</td>
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</table>
| Saizen,            | **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. |
<p>| Saizenprep         |                                                                                                                  | PA                      | PA              | PA                      |</p>
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<thead>
<tr>
<th>Drug Name</th>
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<tbody>
<tr>
<td>Sancuso</td>
<td>Coverage will be provided for:</td>
<td>ST</td>
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<tr>
<td></td>
<td>1. Indication of prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy.</td>
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<td>2. Documented treatment/failure with generic ondansetron (Zofran)/ODT and generic granisetron (Kytril).</td>
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<td>Initial approval: 1 year</td>
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<td></td>
<td>Renewal requires documentation of continuation of chemotherapy.</td>
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<tr>
<td>Sandostatin LAR</td>
<td>Coverage requires documentation to support the following:</td>
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<td>1. Diagnosis of acromegaly, carcinoid tumors or vasoactive intestinal peptide tumors (VIPomas).</td>
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<td>2. Previously tried, responded and tolerated generic immediate release octreotide.</td>
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<tr>
<td>Saphris</td>
<td>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)).</td>
<td>ST</td>
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<tr>
<td>Savella</td>
<td>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).</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Drug Name</td>
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<tr>
<td>Saxenda</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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</table>
| 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 |
<table>
<thead>
<tr>
<th>Drug Name</th>
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<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
<th>Custom Select Drug List</th>
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</thead>
</table>
| 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 |
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>HMO Criteria</th>
</tr>
</thead>
</table>
| **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) |
| **Simponi** | Coverage is provided for members 18 years of age or older for the treatment of:  
  • **Ankylosing spondylitis** in situations where the member has experienced treatment failure of or intolerance to TWO of the following: Cosentyx, Enbrel, or Humira.  
  • **Moderate to severe rheumatoid arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Enbrel, Humira, or Xeljanz/XR.  
  • **Psoriatic arthritis** in situations where the member has experienced treatment failure of or intolerance to a 3-month trial of two disease modifying anti-rheumatic drug (DMARD) taken at the same time, one of them being methotrexate, and TWO of the following: Cosentyx, Enbrel, Humira, or Stelara.  
  Coverage is provided for the treatment of ulcerative colitis in members 18 years of age or older who have experienced treatment failure of or intolerance to an adequate course of systemic corticosteroids or immunomodulatory medication and Humira. |

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<tr>
<th>Comprehensive Drug List</th>
<th>Custom Drug List</th>
<th>Custom Select Drug List</th>
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<tbody>
<tr>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td>PA</td>
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<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
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<tr>
<td>Sirturo</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. 18 years of age or older</td>
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<tr>
<td></td>
<td>2. Treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB)</td>
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<tr>
<td>Sitavig</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>Trial and failure of all of the following:</td>
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<tr>
<td></td>
<td>1. Generic oral acyclovir (Zovirax)</td>
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<td></td>
<td>2. Generic valacyclovir (Valtrex).</td>
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<tr>
<td>Skelaxin (metaxalone)</td>
<td>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).</td>
<td>PA</td>
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<tr>
<td>Solaraze (diclofenac sodium)</td>
<td>Coverage requires documentation to support the following:</td>
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<tr>
<td></td>
<td>1. Diagnosis of actinic keratosis</td>
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<td></td>
<td>2. Trial and treatment failure of 3 different treatment courses using cryotherapy or phototherapy</td>
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<td></td>
<td>3. Trial of 2 topical generic or preferred agents which may include generic fluorouracil (Efudex) or generic imiquimod (Aldara)</td>
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<td></td>
<td>Approve for 3 months</td>
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<td></td>
<td>Renewal criteria: Documentation of recurrence and/or new lesions</td>
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<td>Drug Name</td>
<td>HMO Criteria</td>
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</tbody>
</table>
| 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                     |
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<tbody>
<tr>
<td>Soolantra</td>
<td>Coverage requires documentation to support the following:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
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<td>Trial and failure of all of the following:</td>
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<tr>
<td></td>
<td>1. Generic topical metronidazole.</td>
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<td>2. Generic topical sulfacetamide 10%-sulfur 5%.</td>
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<td>3. Generic oral tetracycline, generic doxycycline or generic minocycline.</td>
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<tr>
<td>Sovaldi</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
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<tr>
<td></td>
<td>1. Age 18 years or older</td>
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<td></td>
<td>2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4</td>
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<td>3. Trial of preferred medication: Epclusa or Zepatier</td>
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<td>4. Documentation of previous treatment experience for Hepatitis C</td>
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<td>5. Documentation of compensated or decompensated cirrhosis</td>
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<td>6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist.</td>
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<td>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</td>
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<tr>
<td>Spritam</td>
<td>Coverage requires all of the following be met:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Treatment of seizure disorder/epilepsy</td>
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<td>2. Member is unable to swallow tablets or capsules</td>
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<td></td>
<td>3. Trial of 3 generic or preferred alternatives, one of which must be generic levetiracetam (Keppra) solution.</td>
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<tr>
<td>Sprycel*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<tr>
<td>Staxyn</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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</table>
| 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 |
<table>
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<tr>
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<td>Stelara</td>
<td>Coverage requires documentation to support the following:</td>
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<td>1. Diagnosis of psoriasis</td>
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<td>2. Treatment with phototherapy or photo chemotherapy was ineffective, contraindicated, or not tolerated.</td>
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<td>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).</td>
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<td></td>
<td>OR</td>
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<tr>
<td></td>
<td>1. Diagnosis of psoriatic arthritis</td>
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<td></td>
<td>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).</td>
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<td></td>
<td>OR</td>
<td></td>
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<tr>
<td></td>
<td>1. Crohn’s disease: treatment of adult patients with active Crohn’s disease</td>
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<td></td>
<td>2. Conventional therapy (examples: corticosteroids, immunomodulators) has been ineffective, contraindicated or not tolerated based on clinical documentation</td>
<td></td>
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</tr>
<tr>
<td>Stendra</td>
<td>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.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Stivarga*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
<tr>
<td>Drug Name</td>
<td>HMO Criteria</td>
<td>Comprehensive Drug List</td>
<td>Custom Drug List</td>
<td>Custom Select Drug List</td>
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<tr>
<td><strong>Strepsiq</strong></td>
<td>Coverage is provided for the treatment of pediatric-onset hypophosphatasia in situations where clinical documentation of the member’s active disease manifestations has been submitted to the plan.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
</tr>
</tbody>
</table>
| **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          |
<p>| <strong>Subsys</strong>      | 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             |
| <strong>Subutex</strong> (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                      |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>HMO Criteria</th>
<th>Comprehensive Drug List</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sumavel Dosepro</td>
<td>Coverage requires documentation to support the following:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>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)).</td>
<td></td>
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<tr>
<td>Sutent*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Symdeko</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td></td>
<td>1. Age &gt; 12 years old</td>
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<tr>
<td></td>
<td>2. Diagnosis of cystic fibrosis (CF)</td>
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<td></td>
<td>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</td>
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<td>4. Prescribed by a cystic fibrosis expert</td>
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<td></td>
<td>Initial authorization period: 1 year</td>
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<td></td>
<td>Renewal requires documentation of improvement in CF symptoms</td>
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<tr>
<td>Symproic</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Diagnosis of opioid induced constipation</td>
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<td></td>
<td>2. Age ≥ 18 years of age</td>
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<td>3. Trial and failure or intolerance to all of the following:</td>
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<td></td>
<td>a. Osmotic laxative</td>
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<td>b. Stimulant laxative used in combination with a stool softener</td>
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<td></td>
<td>c. Amitiza</td>
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<td>Drug Name</td>
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<tr>
<td>Syprine</td>
<td>Coverage is provided for the treatment of Wilson’s disease in situations where the member has experienced treatment failure of, intolerance to, or contraindication to Depen.</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Taclonex ointment</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>(calcipotriene/beta methasone)</td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Taclonex topical suspension</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
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<td>PA</td>
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<tr>
<td></td>
<td>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</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Tafinlar*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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</table>
| Taltz     | Coverage requires the following be met:  
1. Age ≥ 18 years old  
2. Diagnosis of psoriasis  
3. Trial and failure or contraindication to phototherapy or photochemotherapy  
4. Trial and failure or intolerance to at least one generic oral systemic agent for plaque psoriasis (i.e. cyclosporine, methotrexate, Acitretin)  
5. Trial and failure or intolerance to two of the following: Cosentyx, Humira, Otezla or Stelara  
OR  
1. Diagnosis of psoriatic arthritis  
2. Trial and failure or intolerance to one Disease Modifying Anti-Rheumatic Drug (DMARD). (Examples of DMARDS include methotrexate, sulfasalazine, azathioprine)  
3. Trial and failure or intolerance to two of the following: Cosentyx, Enbrel, Humira, Stelara. | PA | PA | Not Covered |
<p>| 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 |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Tanzeum</td>
<td>Coverage requires documentation to support the following:&lt;br&gt;1. Has tried at least one preferred oral therapy, preferably metformin, unless contraindicated.&lt;br&gt;2. Trial of all preferred products: Byetta, Bydureon/BydureonBCise, Trulicity and Victoza.</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tarceva*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>PA</td>
<td>PA</td>
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<tr>
<td><strong>Targretin capsules</strong>&lt;sup&gt;*&lt;/sup&gt; <em>(bexarotene)</em></td>
<td>Coverage requires documentation to support the following:&lt;br&gt;1. Diagnosis of cutaneous T-cell lymphoma (CTCL)&lt;br&gt;2. Treatment failure or intolerance to at least one systemic therapy  &lt;br&gt;Initial approval: 1 year&lt;br&gt;Renewal: No evidence of disease progression</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Targretin gel</td>
<td>Coverage is provided for the treatment of cutaneous T-cell lymphoma (CTCL) where the member has experienced treatment failure of or intolerance to at least one systemic therapy.</td>
<td>PA</td>
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<tr>
<td>Tasigna&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>Drug Name</td>
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</table>
| **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 corticosteroids, immunoglobulins or splenectomy  
4. Current platelet 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 |
<table>
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<tr>
<th>Drug Name</th>
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<th>Custom Drug List</th>
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</thead>
</table>
| **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 is provided for the prevention of cystine (kidney) stone formation for members with a urinary cystine concentration greater than 500 mg/day who are refractory to ALL of the following treatments: increased fluid intake, restriction of sodium and animal protein, and urine alkalinization therapy with Urocit-K (potassium citrate). Continuation of therapy requires urinary cystine concentration less than 250 mg/L. | PA                       | PA               | PA                       |
| **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           |
<table>
<thead>
<tr>
<th>Drug Name</th>
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<th>Custom Drug List</th>
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</thead>
</table>
| 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             |
<p>| 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                      |</p>
<table>
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<tbody>
<tr>
<td>Tremfya</td>
<td>Coverage is provided for members 18 years of age or older for the treatment of moderate to severe plaque psoriasis in situations where the member has experienced treatment failure of or intolerance to Humira.</td>
<td>PA</td>
<td>PA</td>
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</tbody>
</table>
| 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 |
| 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 |
<p>| Tykerb*   | Coverage is provided for the treatment of the FDA approved indications. | PA | PA | PA |</p>
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<tr>
<th>Drug Name</th>
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</table>
| 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                      |
| 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            |
<p>| 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                      |</p>
<table>
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<tr>
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<th>Custom Drug List</th>
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</tr>
</thead>
</table>
| 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 |
| 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 |
<table>
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<tr>
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</table>
| 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          |
| 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          |
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<tr>
<td>Viberzi</td>
<td>Coverage requires documentation to support the following:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Diagnosis of Irritable Bowel Syndrome with diarrhea (IBS-D)</td>
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<td>2. Trial of all of the following:</td>
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<tr>
<td></td>
<td>a. Loperamide</td>
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<td>b. Antispasmodic (ex. Dicyclomine, hyoscyamine)</td>
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<td>c. Tricyclic antidepressant (ex. nortriptyline)</td>
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<tr>
<td>Viibryd, dosepak</td>
<td>Requires trial and failure of at least three generic or preferred antidepressant agents</td>
<td>PA</td>
<td>PA</td>
<td>PA</td>
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<tr>
<td>Vivlodex</td>
<td>Coverage will be provided when all of the following have been met:</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td></td>
<td>1. Diagnosis of osteoarthritis</td>
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<td></td>
<td>2. Trial and failure of generic meloxicam</td>
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<td></td>
<td>3. Trial and failure of two other preferred oral NSAIDs</td>
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<tr>
<td>Vogelxo</td>
<td>Coverage requires documentation of androgen deficiency confirmed by:</td>
<td>ST</td>
<td>ST</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>1. Two morning testosterone levels in the past year below normal range.</td>
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<tr>
<td></td>
<td>2. For BMI &gt; 30, two morning free testosterone levels must be submitted.</td>
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<td></td>
<td>3. At least two signs or symptoms specific to testosterone deficiency</td>
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<td></td>
<td>Renewal criteria:</td>
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<tr>
<td></td>
<td>1. Testosterone levels are at or below normal range</td>
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<td>2. Improvement in signs or symptoms specific to testosterone deficiency</td>
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| 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 |
<p>| Xalkori* | Coverage is provided for the treatment of the FDA approved indications. | PA | PA | PA |</p>
<table>
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<th>Drug Name</th>
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| 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  
  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 |
<p>| 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 |</p>
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| **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 |
<p>| | PA | PA | Not Covered |</p>
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<tr>
<td>Xuriden</td>
<td>Coverage is provided for the treatment of hereditary orotic aciduria.</td>
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<tr>
<td>Xyrem</td>
<td>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.</td>
<td>PA</td>
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<td>Yonsa</td>
<td>Coverage requires documentation of the following: FDA approved indications</td>
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<tr>
<td>Zavesca</td>
<td>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.</td>
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<tr>
<td>Zejula*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>Zelboraf*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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<td>Zembrace Symtouch</td>
<td>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)).</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<td>Zepatier</td>
<td>Coverage requires documentation of the following:&lt;br&gt;1. Age 18 years or older&lt;br&gt;2. Diagnosis of Chronic Hepatitis C genotype 1 or 4&lt;br&gt;3. For genotype 1a patients, test results for NS5a resistance-associated polymorphisms&lt;br&gt;4. Documentation of previous treatment experience for Hepatitis C&lt;br&gt;5. Documentation of compensated or decompensated cirrhosis&lt;br&gt;6. Prescribed by a hepatologist, gastroenterologist or infectious disease specialist. &lt;br&gt;Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling.</td>
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<td>Zetonna</td>
<td>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).</td>
<td>ST</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Zipsor</td>
<td>Coverage requires documentation to support the following:&lt;br&gt;1. Diagnosis of acute pain&lt;br&gt;2. Trial and failure of oral diclofenac&lt;br&gt;3. Trial and failure of two other preferred oral NSAIDs</td>
<td>PA</td>
<td>PA</td>
<td>Not Covered</td>
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<tr>
<td>Zohydro ER</td>
<td>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).&lt;br&gt;<strong>Note:</strong> Coverage will not be provided if the patient is on more than one long acting narcotic concurrently.</td>
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<td>Zolinza*</td>
<td>Coverage is provided for the treatment of the FDA approved indications.</td>
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| 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. |
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<tr>
<td>Zomig nasal spray</td>
<td>Coverage requires trial and treatment failure or intolerance of two generic triptans. (Examples include: generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT).</td>
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**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.
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</table>
| 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.