2024

Prior Authorization Protocols

- Imperial Senior Value (HMO C-SNP) 005
- Imperial Traditional (HMO) 007
- Imperial Dual Plan (HMO D-SNP) 011
- Imperial Dynamic Plan (HMO) 012
- Imperial Strong (HMO) 014

IMPERIAL HEALTH PLAN
OF CALIFORNIA

Part D Utilization Management

Imperial Health Plan of California (HMO) (HMO SNP) applies several Quality Assurance and Utilization Management Initiatives that are designed to improve quality, prevent over- and under- utilization and reduce costs. These programs include but are not limited to Medication Therapy Management, Concurrent Drug Utilization Review, and Retrospective Drug Utilization.

CONCURRENT DRUG REVIEW

Imperial Health Plan has policies and procedures designed to ensure that a review of the prescribed drugs is performed at the point of sale or distribution before a prescription is dispensed to a member. Imperial Health Plan, through its Pharmacy Benefits Manager (PBM) MedImpact, promotes appropriate dispensing and use of drugs to ensure high quality of care and cost- effective therapy.

On-line reviews or edits include but are not limited to:

- Duplicate Drug Class
- Drug Age/Gender Edit
- Over/Under utilization
- Incorrect Drug Dosage/Duration of Therapy
- Drug-to-Disease Contraindication
- Drug/Allergy Edits

This program is not considered a benefit.

RETROSPECTIVE DRUG UTILIZATION

Imperial Health Plan utilizes a retrospective Drug Utilization Review (DUR). The DUR is designed to provide ongoing periodic examination of claims data and other records through a computerized drug claims and information retrieval system. The system being used to identify patterns of inappropriate or medically unnecessary drug use associated with specific drugs or groups of drugs.

These DUR reviews include but are not limited to the following:

- Alerts to prescribers on drug related therapy problems.
- Brand and Generic drug utilization with provision of alternative ways to improve costs.

Formulary ID: 24455-Version 22 and 24456-Version 21
Last Updated: 11192024
Effective: 12012024

- Physician utilization reports that identify over/under utilization, patterns of prescribing, poly-pharmacy patients.

This program is not considered a benefit.

You can call us at: 1-877-391-1105 (seven days a week, 24 hours a day) if you have any additional questions. If you have a hearing or speech impairment, please call us at TTY 711.

IR_257 H5496 Prior Auth Protocols_C ENG 11/16/23

ABIRATERONE

Products Affected

- *abiraterone*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Castration-resistant metastatic prostate cancer (CRPC), or B.) High risk, castration-sensitive metastatic prostate cancer (CSPC). For treatment of CRPC and CSPC, abiraterone will be used in combination with prednisone AND one of the following applies 1.) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g. leuprolide, triptorelin), OR 2) Patient has received bilateral orchiectomy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Severely impaired liver or kidney function, B.) Chronic abnormally elevated blood lipid values, C.) Concomitant use of methotrexate or tetracyclines, D.) Pregnancy
Required Medical Information	Diagnosis of severe, recalcitrant psoriasis (including plaque, guttate, erythrodermic palmar- plantar and pustular) AND patient must have tried and failed, contraindication or intolerance to one formulary first line agent (e.g., Topical Corticosteroids (betamethasone, fluocinonide, desoximetasone),Topical Calcipotriene/Calcitriol, Topical Calcipotriene, OR Topical Tazarotene)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ACTHAR

Products Affected

- ACTHAR
- ACTHAR SELFJECT SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: 1) DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS, AND 2) CONTINUES TO POSSESS CONTRAINDICATION TO IV CORTICOSTEROIDS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic granulomatous disease for use in reducing the frequency and severity of serious infections, or B.) Severe, malignant osteopetrosis (SMO)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form, B.) Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline), C.) Pregnancy, or D.) Patients with pulmonary hypertension associated with idiopathic interstitial pneumonia
Required Medical Information	Diagnosis of one of the following A.) Pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.), or B.) Chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable (Female patients must be enrolled in the ADEMPAS REMS program)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AKEEGA

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) HAS CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic anaplastic lymphoma kinase (ALK) positive non-small cell lung cancer as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALPHA-1 PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Immunoglobulin A (IgA) deficiency with antibodies against IgA
Required Medical Information	Diagnosis of alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency in adult patients with emphysema
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALUNBRIG

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of anaplastic lymphoma kinase-positive (ALK) metastatic non-small cell lung cancer (NSCLC)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALVAIZ

Products Affected

- ALVAIZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: 1) PLATELET COUNT IS LESS THAN 30 X 10^9/L FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS, OR 2) PLATELET COUNT IS LESS THAN 50 X 10^9/L FROM AT LEAST 2 SEPARATE LABS IN THE LAST 3 MONTHS AND HAD A PRIOR BLEEDING EVENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 2 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: ITP: 1) TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY, AND 2) NO CONCURRENT USE WITH OTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RAS) OR SPLEEN TYROSINE KINASE (SYK) INHIBITOR. RENEWAL: ITP: 1) IMPROVEMENT IN PLATELET COUNT FROM BASELINE OR REDUCTION IN BLEEDING EVENTS, AND 2) NO CONCURRENT USE WITH OTHER TPO-RAS OR SYK INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Pregnancy, or B.) Idiopathic pulmonary fibrosis (IPF), including those with pulmonary hypertension
Required Medical Information	Diagnosis of pulmonary arterial hypertension classified as WHO Group I, confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ANKTIVA

Products Affected

- ANKTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	40 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS), B.) Deficiency of interleukin-1 receptor antagonist (DIRA) and patient requires maintenance therapy for remission, or C.) Recurrent pericarditis (RP) and reduction in risk of recurrence
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	Known sensitivity to any aminoglycoside
Required Medical Information	Diagnosis of pulmonary Mycobacterium avium complex (MAC) infection and used as part of a combination antibacterial regimen in treatment refractory patients (greater than 6 months of a multidrug background regimen)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUGTYRO

Products Affected

- AUGTYRO

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	Iron overload syndrome (e.g. hemochromatosis)
Required Medical Information	Diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD) on dialysis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or nephrologist
Coverage Duration	12 months
Other Criteria	Ferric Citrate is NOT approvable for iron deficiency anemia per Part D law
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUSTEDO

Products Affected

- AUSTEDO
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4)

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Suicidal ideation and/or untreated or inadequately treated depression in a patient with Huntington's Disease, B.) Hepatic impairment, C.) Concomitant use of MAOIs, reserpine, tetrabenazine, or valbenazine
Required Medical Information	Diagnosis of one of the following A.) Chorea associated with Huntington's disease (Huntington's chorea), or B.) Tardive dyskinesia
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AYVAKIT

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Unresectable or metastatic gastrointestinal stromal tumor, with a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations, or B.) Advanced Systemic Mastocytosis (AdvSM), including aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SMAHN), or mast cell leukemia (MCL), and platelet count of at least 50,000/mcL, or C.) indolent systemic mastocytosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BALVERSA

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma and both of the following 1.) Susceptible fibroblast growth factor receptor (FGFR)3 or FGFR2 genetic alterations confirmed by an FDA-approved diagnostic test, and 2.) Patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Active, autoantibody-positive, system lupus erythematosus (SLE), or B.) Active lupus nephritis and patient is receiving standard therapy
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or rheumatologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Existence of, or history of severe psychiatric disorders (severe depression, suicidal ideation, or suicide attempt), B.) Hypersensitivity to interferons including interferon alfa-2b or excipients, C.) Hepatic impairment (Child-Pugh B or C), D.) History or presence of active serious or untreated autoimmune disease, or E.) Immunosuppressed transplant recipients
Required Medical Information	Diagnosis of polycythemia vera
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BEXAROTENE GEL

Products Affected

- *bexarotene topical*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of primary cutaneous T-cell lymphoma (CTCL Stage 1A/1B) and patient had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) indicated for cutaneous manifestations of CTCL
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BEXAROTENE ORAL

Products Affected

- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma (CTCL) and patient is not a candidate for or had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) for cutaneous manifestations of CTCL
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an dermatologist, hematologist, or oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BOSENTAN

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant cyclosporine A or glyburide therapy, or B.) Pregnancy
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) and patient has New York Heart Association (NYHA) Functional Class II-IV, confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BOSULIF

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or inadequate response to prior therapy, or B.) Newly diagnosed chronic phase Philadelphia chromosome-positive (Ph+) CML
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRAFTOVI

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) unresectable or metastatic melanoma with documented BRAF V600E or V600K mutation as detected by a FDA-approved test and used in combination with binimetinib, or B.) metastatic colorectal cancer with documented BRAF V600E mutation as detected by a FDA-approved test, patient has received prior therapy, and braftovi used in combination with cetuximab.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRONCHITOL

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Cystic fibrosis of the lung
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRUKINSA

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A.) mantle cell lymphoma (MCL) and patient has received at least one prior therapy, B.) Treatment of adult patients with Waldenstrom macroglobulinemia, C.) Treatment of adult patients with relapsed or refractory marginal zone lymphoma who have received at least one anti-CD20-based regimen, D.) Chronic lymphocytic leukemia, or E.) Small lymphocytic lymphoma
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BYLVAY

Products Affected

- BYLVAY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) progressive familial intrahepatic cholestasis-associated pruritus, or B) Alagille syndrome (ALGS)-associated cholestatic pruritus
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CABLIVI

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) and used in combination with plasma exchange and immunosuppression therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced renal cell carcinoma, B.) Advanced hepatocellular carcinoma (HCC) and patient has been previously treated with sorafenib, C.) Advanced renal cell carcinoma and used as first line treatment in combination with nivolumab or D.) treatment of adults and pediatric patients 12 years and older with locally advanced or metastatic differentiated thyroid cancer that has progressed following VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CALQUENCE

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Mantle cell lymphoma (MCL) and patient has received at least 1 prior therapy, B.) Chronic lymphocytic leukemia (CLL), or C.) Small lymphocytic lymphoma (SLL)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAMZYOS

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) in adult patients
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of metastatic or unresectable locally advanced medullary thyroid cancer (MTC) AND disease is symptomatic or progressive
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CARGLUMIC ACID

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) N-acetyl glutamate synthase (NAGS) deficiency (confirmed by appropriate genetic testing) with acute or chronic hyperammonemia, or B.) Propionic or methylmalonic acidemia with acute hyperammonemia
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis (confirmed by appropriate diagnostic or genetic testing) and patient has Pseudomonas aeruginosa lung infection confirmed by positive culture
Age Restrictions	7 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CNS STIMULANTS

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Obstructive sleep apnea (OSA) confirmed by sleep lab evaluation, B.) Narcolepsy confirmed by sleep lab evaluation, or C.) Shift work disorder (SWD)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COMETRIQ

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsed or refractory chronic lymphocytic leukemia (CLL), or B.) Relapsed or refractory small lymphocytic lymphoma (SLL). For CLL or SLL, the patient must have history of at least 2 prior therapies
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CORLANOR

Products Affected

- *ivabradine*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Decompensated acute heart failure, B.) hypotension (i.e. blood pressure less than 90/50 mmHg), C.) sick sinus syndrome or sinoatrial block or 3rd degree AV block (unless a functioning demand pacemaker is present), D.) bradycardia (i.e., resting heart rate less than 60 bpm prior to treatment), E.) Severe hepatic impairment (Child-Pugh C), F.) Pacemaker dependent (heart rate maintained exclusively by the pacemaker), G.) Concomitant use of strong CYP3A4 inhibitors
Required Medical Information	Diagnosis of one of the following A.) Adult patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate 70 beats per minute or more and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use, or B.) Pediatric patients with stable, symptomatic heart failure due to dilated cardiomyopathy and are in sinus rhythm with an elevated heart rate
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX INTRAVENOUS
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Ankylosing spondylitis and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Enbrel, Humira, Rinvoq), B.) Moderate to severe plaque psoriasis in adults and patient has trail and failure, contraindication, or intolerance to two preferred products, (i.e. Enbrel, Humira, Skyrizi, Stelara), C.) Moderate to severe plaque psoriasis in patients 6 years to less than 18 years of age and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Enbrel, Stelara), D.) Active psoriatic arthritis in adult patient and has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Enbrel, Humira, Rinvoq, Skyrizi, Stelara), E.) Active psoriatic arthritis in patients 2 years to less than 18 years of age, F.) Non-radiographic axial spondyloarthritis and patient has trail and failure, contraindication, or intolerance to one preferred product, (i.e. Rinvoq), or G.) Active enthesitis-related arthritis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.)unresectable or metastatic malignant melanoma with BRAF V600E OR V600K mutation, and documentation of combination therapy with vemurafenib (Zelboraf), or B.) Histiocytic neoplasms
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTAGON

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	Known serious hypersensitivity to penicillamine or cysteamine
Required Medical Information	Diagnosis of nephropathic cystinosis confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTEAMINE OPHTH

Products Affected

- CYSTADROPS
- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystinosis and patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) History of seizure. B.) Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute)
Required Medical Information	Diagnosis of multiple sclerosis and patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DAURISMO

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of newly diagnosed acute myeloid leukemia (AML) and used in combination with cytarabine in patients 75 years of age or older OR in patients that have comorbidities that preclude use of intensive induction chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERASIROX

Products Affected

- *deferasirox*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Creatinine clearance less than 40 mL/min, B.) Poor performance status, C.) Platelet count less than 50 x 10(9)/L, D.) Advanced malignancy, E.) High-risk myelodysplastic syndrome (MDS)
Required Medical Information	Diagnosis of one of the following A.) Chronic iron overload in patients with non-transfusion-dependent thalassemia syndromes who have liver iron concentrations of at least 5 mg Fe/g dry weight AND serum ferritin level greater than 300 mcg/L, or B.) Chronic iron overload due to blood transfusions (transfusion hemosiderosis) as evidenced by transfusion of at least 100 mL/kg packed red blood cells AND serum ferritin level greater than 1000 mcg/L
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERIPRONE

Products Affected

- *deferiprone*
- FERRIPROX (2 TIMES A DAY)
- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 1,000 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Must meet all of the following 1.) Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease, or other anemias, 2.) Patient has failed prior chelation therapy, and 3.) Patient has an absolute neutrophil count greater than 1.5 x 10(9)/L
Age Restrictions	3 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe myoclonic epilepsy in infancy (Dravet syndrome) in patients taking clobazam
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Actinic keratosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIFICID

Products Affected

- DIFICID ORAL SUSPENSION FOR RECONSTITUTION
- DIFICID ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of diarrhea associated with clostridioides difficile infection and patient has had an inadequate treatment response, intolerance, or contraindication to generic oral vancomycin
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	4 weeks
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DOJOLVI

Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Long-chain fatty acid oxidation disorder (LC-FAOD)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	Sesame oil hypersensitivity
Required Medical Information	Diagnosis of one of the following A.) Anorexia associated to AIDS, or B.) Chemotherapy-induced nausea and vomiting
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	B vs D determination required per CMS guidance
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DROXIDOPA

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) caused by primary autonomic failure (e.g., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe atopic dermatitis and if patient is 2 years or older has trial/failure, contraindication, or intolerance to two of the following 1.) Topical corticosteroid and/or 2.) Topical calcineurin inhibitor, B.) Eosinophilic phenotype or oral corticosteroid-dependent moderate to severe asthma and used as an adjunct treatment, or C.) Chronic rhinosinusitis with nasal polyposis and used as an adjunct treatment, D.) Eosinophilic esophagitis, or E.) Prurigo nodularis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EFLORNITHINE

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ELREXFIO

Products Affected

- ELREXFIO 44 MG/1.1 ML VIAL OUTER, SUV, P/F
- ELREXFIO SUBCUTANEOUS SOLUTION 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RELAPSED OR REFRACTORY MULTIPLE MYELOMA: RENEWAL: 1) HAS RECEIVED AT LEAST 24 WEEKS OF TREATMENT WITH ELREXFIO, AND 2) HAS RESPONDED TO TREATMENT (PARTIAL RESPONSE OR BETTER), AND HAS MAINTAINED THIS RESPONSE FOR AT LEAST 2 MONTHS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMGALITY

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic or episodic migraine disorder and patient has documented trial, inadequate response, or contraindication to at least 2 generic formulary drugs used for migraine prevention (i.e., propranolol, topiramate, divalproex, timolol), or B.) Episodic cluster headache
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, or E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENDARI

Products Affected

- *glutamine (sickle cell)*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of sickle cell disease AND one of the following 1.) Patient has acute complications and is being treated with Hydroxyurea, or 2.) Patient has acute complications and is unable to tolerate Hydroxyurea
Age Restrictions	5 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENSPRYNG

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Active Hepatitis B infection, or B.) Active or untreated latent tuberculosis
Required Medical Information	Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) in patients who are anti-aquaporin-4 (AQP4) antibody positive
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, immunologist, or ophthalmologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Lennox-Gastaut syndrome, B.) Severe myoclonic epilepsy in infancy (Dravet syndrome), or C.) Seizures associated with tuberous sclerosis complex (TSC)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPOETIN THERAPY

Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Non-myeloid neoplastic disease and utilized for the treatment of chemotherapy induced anemia, B.) HIV infection and utilized for the treatment of zidovudine induced anemia, C.) Chronic kidney disease resulting in anemia, or D.) High risk surgical candidate status at risk for perioperative blood loss and undergoing elective, noncardiac, or nonvascular surgery
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	B vs D determination required per CMS guidance
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Metastatic basal cell carcinoma, or B.) Locally advanced basal cell carcinoma that has recurred following surgery or the patient is not a candidate for surgery or radiation
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERLEADA

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Nonmetastatic, castration-resistant prostate cancer (nmCRPC), or B.) Metastatic, castration-sensitive prostate cancer (mCSPC). For treatment of nmCRPC and mCSPC, one of the following applies 1.) Used in combination with a gonadotropin-releasing hormone (GnRH) analog, OR 2) Patient has received bilateral orchiectomy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Locally advanced, unresectable, or metastatic pancreatic cancer and erlotinib will be used in combination with gemcitabine, B.) Locally advanced or metastatic non-small cell lung cancer with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility AND one of the following 1.) Erlotinib will be used as first-line treatment, 2.) Failure with at least one prior chemotherapy regimen, or 3.) No evidence of disease progression after four cycles of first-line platinum-based chemotherapy and erlotinib will be used as maintenance treatment
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EVEROLIMUS

Products Affected

- *everolimus (antineoplastic) oral tablet*
- *torpenz*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Hypersensitivity to everolimus or excipients, or B.) Hypersensitivity to rapamycin derivatives (e.g. sirolimus)
Required Medical Information	Diagnosis of one of the following A.) Renal angiomyolipoma and tuberous sclerosis complex (TSC) not requiring immediate surgery, B.) Advanced hormone receptor-positive, HER2 negative breast cancer in postmenopausal women and taken in combination with exemestane, after failure with letrozole or anastrozole, C.) Progressive, well-differentiated, nonfunctional neuroendocrine tumors of gastrointestinal or lung origin and disease is unresectable, locally advanced, or metastatic, D.) Pancreatic progressive neuroendocrine tumors and disease is unresectable, locally advanced, or metastatic, E.) Advanced renal cell carcinoma (RCC) after failure with sunitinib or sorafenib, F.) Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex in patients who are not candidates for curative surgical resection
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EVEROLIMUS SUSPENSION

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Hypersensitivity to everolimus , or B.) Hypersensitivity to rapamycin derivatives (e.g. sirolimus)
Required Medical Information	Diagnosis of one of the following A.) Tuberous sclerosis complex (TSC)-associated partial-onset seizures, or B.) Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex in patients who are not candidates for curative surgical resection
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of spinal muscular atrophy (SMA)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EXKIVITY

Products Affected

- EXKIVITY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with EGFR exon 20 insertion mutations (as confirmed by an FDA-approved test) AND whose disease has progressed on or after platinum-based chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. RENEWAL: 1) NO CONCURRENT USE WITH XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FEBUXOSTAT

Products Affected

- *febuxostat*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of azathioprine or mercaptopurine
Required Medical Information	Diagnosis of Gout and all of the following 1.) documented inadequate treatment response, adverse event, or contraindication to maximally titrated dose of Allopurinol, and 2.) patients with established cardiovascular disease, prescriber attests that benefit of treatment outweighs the risk of treatment
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FENTANYL ORAL

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Use in opioid non-tolerant patients, C.) Known or suspected gastrointestinal obstruction, including paralytic ileus, D.) Acute or severe bronchial asthma and used in an unmonitored setting (absence of resuscitative equipment)
Required Medical Information	Must meet all of the following 1.) Diagnosis of cancer-related breakthrough pain, 2.) Patient is currently receiving/tolerant to around-the-clock opioid therapy for persistent cancer pain, and 3.) Patient and prescriber are enrolled in the TIRF REMS Access Program
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FENTANYL PATCH

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Mild or intermittent pain management, C.) Use in opioid non-tolerant patients, D.) Known or suspected gastrointestinal obstruction, including paralytic ileus, E.) Acute or severe bronchial asthma and used in an unmonitored setting (absence of resuscitative equipment)
Required Medical Information	Must meet all of the following 1.) Patient is opioid tolerant (taking for one week or longer at least 60mg of morphine or equivalent daily) and 2.) Patient has tried at least one extended release oral opioids or is unable to take extended release oral opioids secondary to allergy, adverse events, swallowing difficulty, or uncontrollable nausea/vomiting
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FILSPARI

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Pregnancy or B.) Concomitant use with angiotensin receptor blockers (ARBs), endothelin receptor antagonists (ERAs), or aliskiren
Required Medical Information	Diagnosis of treatment of primary immunoglobulin A (IgA) nephropathy at risk of rapid disease progression, generally a urine protein to creatinine ratio (UPCR) of 1.5 g/g or more, to reduce proteinuria
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FINGOLIMOD

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure, B.) History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker, C.) Baseline QTC interval greater than or equal to 500 milliseconds, D.) Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol)
Required Medical Information	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	10 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant use of an MAOI, or B.) Use within 14 days of discontinuing an MAOI
Required Medical Information	Diagnosis of Severe myoclonic epilepsy in infancy (Dravet syndrome) or seizures associated with Lennox-Gastaut syndrome
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	none
Required Medical Information	Diagnosis of advanced prostate cancer
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FOTIVDA

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory advanced renal cell cancer (RCC) following 2 or more prior systemic therapies
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FRUZAQLA

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) mutation
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of short bowel syndrome and patient is dependent on parenteral support
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GAVRETO

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic RET fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test, B.) Advanced or metastatic RET-mutant medullary thyroid cancer and patient requires systemic therapy, or C.) Advanced or metastatic RET fusion-positive thyroid and patient requires systemic therapy and is radioactive iodine-refractory, when radioactive iodine is appropriate
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) and must meet all of the following 1.) Tumor has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility and 2.) Used as first-line treatment
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test, or B.) Metastatic squamous NSCLC with progression after platinum-based chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLATIRAMER

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLEOSTINE

Products Affected

- GLEOSTINE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Must meet one of the following: A.) Hodgkin's disease in patient who has relapsed during or failed to respond to primary therapy and is being used in combination with other agents OR B.) Intracranial tumor
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLP1

Products Affected

- MOUNJARO
- OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)
- RYBELSUS
- TRULICITY
- VICTOZA SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Must meet all of the following 1.) The drug is prescribed for an FDA-approved indication, 2.) For a diagnosis of Type 2 Diabetes Mellitus the patient has a trial and failure, contraindication or intolerance to metfomin
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 monthd
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GROWTH HORMONE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Use for growth promotion in pediatric patients with closed epiphyses, B.) Acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure, C.) Active malignancy, D.) Active proliferative or severe nonproliferative diabetic retinopathy, E.) Prader-Willi Syndrome in patients who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment

PA Criteria	Criteria Details
Required Medical Information	Diagnosis of pediatric indication: A.) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B.) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C.) CRI and metabolic abnormalities have been corrected, and patient has not had renal transplant D.) SHOX deficiency or Noonan syndrome E.) PWS confirmed by genetic testing, F.) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A.) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone [preferred], glucagon, arginine), B.) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C.) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D.) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HEPATITIS C

Products Affected

- MAVYRET
- *sofosbuvir-velpatasvir*
- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. All genotypes will require trial/failure, contraindication to, or intolerance to Mavyret or Sofosbuvir-Velpatasvir prior to the approval of Vosevi.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy and when other systemic therapies are medically less appropriate, F.) Moderate to severe Crohn's disease in patients who have had an inadequate response to conventional therapy, G.) Moderate to severe ulcerative colitis in patients who have had an inadequate response to immunosuppressants (e.g. corticosteroids, azathioprine), H.) Non-infectious uveitis (including intermediate, posterior, and panuveitis), or I.) Moderate to severe hidradenitis suppurativa
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HYFTOR

Products Affected

- HYFTOR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Facial angiofibroma associated with tuberous sclerosis
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer used in combination with fulvestrant and disease has progressed following endocrine therapy, or B.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer and used in combination with an aromatase inhibitor as initial endocrine-based therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following and used as treatment for acute attacks A.) Hereditary angioedema (HAE) with C1 inhibitor deficiency (Type 1) confirmed by laboratory testing, or B.) HAE with C1 inhibitor dysfunction (Type 2) confirmed by laboratory testing, or C.) HAE with normal C1 inhibitor (Type 3) confirmed by laboratory testing and one of the following 1.) Positive test for an F12, angiopoietin-1, or plasminogen gene mutation, or 2.) Family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, hematologist, or immunologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated, B.) Chronic phase, chronic myeloid leukemia (CML) in adult patients with resistance or intolerance to at least two prior kinase inhibitors, or C.) Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IDHIFA

Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase 2 (IDH2) mutation as detected by an FDA approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B.) Ph+ acute lymphoblastic leukemia (ALL), C.) Gastrointestinal stromal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D.) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E.) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F.) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, or G.) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMBRUVICA

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL), B.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion, C.) Waldenstrom's macroglobulinemia (WM), or D.) Chronic graft vs host disease (cGVHD) after failure of at least one first-line corticosteroid therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMDELLTRA

Products Affected

- IMDELLTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INBRIJA

Products Affected

- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concurrent use with nonselective monoamine oxidase inhibitors (MAOIs) (e.g. phenelzine and tranylcypromine), B.) Recent use (within 2 weeks) with a nonselective MAOI
Required Medical Information	Must meet all of the following A.) Diagnosis of Parkinson's disease and used for intermittent treatment of off episodes, and B.) Concurrent therapy with carbidopa/levodopa
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Active or suspected malignancy, B.) Use for growth promotion in patients with closed epiphyses, or C.) Intravenous administration
Required Medical Information	Diagnosis of one of the following A.) Severe primary insulin-like growth factor-1 (IGF-1) deficiency and utilized for pediatric treatment of growth failure, or B.) Growth hormone (GH) gene deletion and patient has developed neutralizing antibodies to GH and utilized for pediatric treatment of growth failure
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INGREZZA

Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)
- INGREZZA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TD: 1) PRIOR HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: AUSTEDO.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced renal cell carcinoma and patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens), or B.) Advanced renal cell carcinoma and used as first-line therapy in combination with avelumab or pembrolizumab
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INTRAROSA

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, or B.) Known or suspected estrogen-dependent neoplasia
Required Medical Information	Diagnosis of one of the following A.) moderate to severe dyspareunia due to menopause, or B.) atrophic vaginitis due to menopause
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ISTURISA

Products Affected

- ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Cushing's disease in patients for whom pituitary surgery is not an option or has not been curative
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ITRACONAZOLE

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF), B.) Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.), C.) Concurrent use of CYP2D6 inhibitors (e.g., bupropion, fluoxetine, paroxetine, quinidine, terbinafine), D.) Renal or hepatic impairment and concomitant use of colchicine, fesoterodine, solifenacin, or telithromycin, E.) Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), or B.) Onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ITRACONAZOLE SOLN

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF), B.) Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.), C.) Concurrent use of CYP2D6 inhibitors (e.g., bupropion, fluoxetine, paroxetine, quinidine, terbinafine), D.) Renal or hepatic impairment and concomitant use of colchicine, fesoterodine, solifenacin, or telithromycin, E.) Pregnancy
Required Medical Information	Diagnosis of candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IVERMECTIN

Products Affected

- *ivermectin oral*

PA Criteria	Criteria Details
Exclusion Criteria	Prevention or treatment of COVID-19
Required Medical Information	Diagnosis of one of the following: A.) Strongyloidiasis of the intestinal tract or B.) Onchocerciasis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis, B.) Polycythemia vera AND patient has had an inadequate response to or is intolerant of hydroxyurea, C.) Acute graft versus host disease AND disease is refractory to steroid therapy, or D.) Chronic graft-versus-host disease (cGVHD) after failure of corticosteroid therapy (alone or in combination with a calcineurin inhibitor) and up to one additional line of systemic therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JAYPIRCA

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory mantle cell lymphoma (MCL) and is being used after at least two lines of systemic therapy, including a BTK inhibitor
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests, B.) Pregnancy, or C.) Concomitant use with strong or moderate CYP3A4 inhibitors
Required Medical Information	Diagnosis of HoFH as confirmed by one of the following A.) Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (LDLRAP1 or ARH), or B.) Both of the following 1.) Either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL, and 2.) Either xanthoma before 10 years of age or evidence of heterozygous FH in both parents
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis (CF) and the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KESIMPTA

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	Active Hepatitis B infection
Required Medical Information	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe active rheumatoid arthritis and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Humira, Enbrel), B.) Cryopyrin-associated periodic syndromes (i.e., neonatal-onset multisystem inflammatory disease), or C.) Deficiency of interleukin-1 receptor antagonist
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI

Products Affected

- KISQALI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer and one of the following A.) The patient is a pre-or perimenopausal woman or man and the requested drug will be used in combination with an aromatase inhibitor as initial endocrine-based therapy, B.) The patient is a postmenopausal woman or man, the requested drug will be used in combination with an aromatase inhibitor as initial endocrine-based therapy, and the patient has experienced disease progression, an intolerable adverse event, or contraindication to Ibrance (palbociclib) or Verzenio (abemaciclib), C.) The patient is a pre-or perimenopausal woman or man and the requested drug is being used with fulvestrant as initial endocrine-based therapy, or D.) The patient is a postmenopausal woman or man, the requested drug is being used following disease progression on endocrine therapy, and the patient has experienced disease progression, an intolerable adverse event, or contraindication to Ibrance (palbociclib) or Verzenio (abemaciclib)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI FEMARA

Products Affected

- KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer and one of the following A.) The patient is pre-or perimenopausal woman or male and the requested drug will be used as initial endocrine-based therapy, B.) The patient is postmenopausal, the requested drug will be used as initial endocrine-based therapy, and the patient has experienced disease progression, an intolerable adverse event, or contraindication to Ibrance (palbociclib) or Verzenio (abemaciclib)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) pregnancy, B.) coadministration with simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges, C.) concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses, D.) history of unexplained vaginal bleeding, E.) endometrial hyperplasia with atypia or endometrial carcinoma
Required Medical Information	Diagnosis of endogenous Cushing syndrome in patients with type 2 diabetes mellitus or glucose intolerance and must meet all of the following 1.) Used to control hyperglycemia secondary to hypercortisolism, and 2.) Patient has failed or is not a candidate for surgery
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KOSELUGO

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of neurofibromatosis type 1 (NF1) in a patient who has symptomatic, inoperable plexiform neurofibromas (PN)
Age Restrictions	2 years of age to 17 years of age
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KRAZATI

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as determined by an FDA-approved test and patient has received at least one prior systemic therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND meets one of the following A.) Used in combination with capecitabine in a patient who has received prior therapy including an anthracycline, a taxane, and trastuzumab, OR B.) Used in combination with letrozole in a postmenopausal female for whom hormonal therapy is indicated
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LAZCLUZE

Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Multiple myeloma and medication will be used in combination with dexamethasone, B.) Autologous hematopoietic stem-cell transplantation (HSCT) in multiple myeloma patients, C.) Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality or without additional cytogenetic abnormalities, D.) Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib, E.) Follicular lymphoma and used in combination with rituximab, or F.) Marginal zone lymphoma and used in combination with rituximab
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LENVIMA

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer, B.) Advanced renal cell carcinoma, in combination with everolimus, following one prior anti-angiogenic therapy, C.) Unresectable hepatocellular carcinoma, first-line therapy, D.) Advanced endometrial carcinoma that is not microsatellite instability-high or mismatch repair deficient, in combination with pembrolizumab, when disease has progressed following prior systemic therapy and patient is not a candidate for curative surgery or radiation, or E.) Advanced renal cell carcinoma, in combination with pembrolizumab and used as first-line therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed, B.) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, C.) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT, D.) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy, E.) Hematopoietic subsyndrome of acute radiation syndrome (H-ARS) or F.) Autologous peripheral blood stem cell transplant, Following myeloablative chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LEUPROLIDE

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- *leuprolide (3 month)*
- *leuprolide subcutaneous kit*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- LUPRON DEPOT-PED
- LUPRON DEPOT-PED (3 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Pregnancy, B.) Undiagnosed abnormal uterine bleeding
Required Medical Information	Diagnosis of one of the following A.) Advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, and 45 mg 6-month, Leuprolide 1mg/0.2mL), Lupron Depot and Leuprolide acetate 1mg/0.2mL: Patient has failed or is intolerant to Eligard, B.) Endometriosis (3.75 mg 1-month and 11.25 mg 3-month depots only), C.) Anemia due to uterine leiomyomata (Fibroids) (3.75 mg 1-month and 11.25 mg 3-month depots only) and patient is preoperative, or D.) Central precocious puberty (idiopathic or neurogenic) in children
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

- *dermacinrx lidocan 5% patch outer*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocan iii*
- *tridacaine ii*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Pain associated with diabetic neuropathy, B.) Pain associated with cancer-related neuropathy, C.) Post-herpetic neuralgia, D.) Chronic back pain, or E.) Osteoarthritis of the knee or hip
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LINEZOLID

Products Affected

- *linezolid in dextrose 5%*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant use of an MAOI, or B.) Use within 14 days of discontinuing an MAOI
Required Medical Information	Diagnosis of one of the following A.) Community acquired pneumonia, B.) Hospital-acquired pneumonia, C.) Vancomycin-resistant Enterococcus faecium infection, D.) Complicated skin and skin structure infections, or E.) Uncomplicated skin and skin structure infections
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIVMARLI

Products Affected

- LIVMARLI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cholestatic pruritus in patients with Alagille syndrome (ALGS)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIVTENCITY

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of post-transplant cytomegalovirus (CMV) infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic colorectal cancer, previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy, or B.) Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan and if appropriate, HER2/neu-targeted therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LOQTORZI

Products Affected

- LOQTORZI

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	NASOPHARYNGEAL CARCINOMA (NPC): FIRST LINE TREATMENT: 24 MOS, PREVIOUSLY TREATED: LIFETIME.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A4 inducers
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUMAKRAS

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as determined by an FDA-approved test, and patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)
Required Medical Information	Initial: Diagnosis of systemic lupus erythematosus (SLE) with active lupus nephritis (LN) Classes III, IV, V (alone or in combination), and all of the following: 1.) Baseline renal function of 45 mL/min/1.73 m2 or greater, 2.) Will be used in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate, oral steroids, etc). Renewal: patient continues to benefit from the medication.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or nephrologist
Coverage Duration	Initial: 12 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYNPARZA

Products Affected

- LYNPARZA ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) HER2-negative, deleterious or suspected deleterious germline BRCA mutated metastatic breast cancer AND previous treatment with chemotherapy in neoadjuvant, adjuvant, or metastatic setting, B.) Recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer AND used for maintenance treatment in patients in complete or partial response to platinum-based chemotherapy (e.g. cisplatin, carboplatin), C.) Deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with complete or partial response to first-line platinum-based chemotherapy, D.) Deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma and disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen, E.) Advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA-mutation and/or genomic instability AND are using in combination with bevacizumab for maintenance treatment, F.) Deleterious or suspected deleterious germline or somatic homologous recombination repair gene mutated metastatic castration-resistant prostate cancer in patients who have progressed following prior treatment with enzalutamide or abiraterone, G.) HER2-negative, deleterious or suspected deleterious germline BRCA mutated high-risk early breast cancer AND patient has been previously treated with neoadjuvant or adjuvant chemotherapy, or H) deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) used in combination with abiraterone and prednisone or prednisolone
Age Restrictions	18 years of age and older

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYTGOBI

Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements and previously treated
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Exclusion Criteria	Inadequate marrow reserve
Required Medical Information	Diagnosis of Hodgkin's Disease, Stages III and IV and used in combination with other anticancer drugs
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MAYZENT

Products Affected

- MAYZENT
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) CYP2C9*3/*3 genotype, B.) In the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III-IV heart failure, or C.) Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease and the following A.) Patients with relapsing forms of multiple sclerosis have history of/or contraindication to Avonex, Betaseron, Copaxone/Glatiramer, Gilenya/Fingolimod, or Dimethyl Fumarate
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEKINIST

Products Affected

- MEKINIST ORAL RECON SOLN
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and used in combination with dabrafenib and no locoregional treatment options, B.) Malignant melanoma with lymph node involvement and following complete resection with BRAF V600E or V600K mutations and used in combination with dabrafenib, C.) Unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutations and used in combination with dabrafenib or as monotherapy, D.) Metastatic non-small cell lung cancer, with BRAF V600E mutation, in combination with dabrafenib, E.) Unresectable or metastatic solid tumors with BRAF V600E mutation, in combination with dabrafenib, and have progressed following prior treatment and have no satisfactory alternative treatment options, F.) Low-grade glioma with a BRAF V600E mutation and require systemic therapy, in combination with dabrafenib
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA approved test AND used in combination with encorafenib
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MIGLUSTAT

Products Affected

- *miglustat*
- *yargesa*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate type 1 Gaucher disease and patient is not a candidate for enzyme replacement therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MIPLYFFA

Products Affected

- MIPLYFFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NIEMANN-PICK DISEASE TYPE C (NPC): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST OR GENETICIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	NPC: RENEWAL: IMPROVEMENT OR SLOWING OF DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MS INTERFERONS

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NAMZARIC

Products Affected

- NAMZARIC

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Hypersensitivity to memantine, donepezil, or excipients, or B.) Hypersensitivity to piperidine derivatives
Required Medical Information	Diagnosis of moderate to severe dementia associated with Alzheimer's disease
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of hypoparathyroidism and used to control hypocalcemia
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Early stage HER2-positive breast cancer and used following adjuvant trastuzumab therapy, or B.) Advanced or metastatic HER2-positive breast cancer, used in combination with capecitabine, AND patient has received 2 or more prior anti-HER2-based regimens in the metastatic setting
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, used in combination with lenalidomide and dexamethasone, AND patient has history of at least 1 prior therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NITISINONE

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 confirmed by one of the following A.) Biochemical testing (e.g., detection of succinylacetone in urine), or B.) DNA testing (mutation analysis)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Non-metastatic, castration-resistant prostate cancer (nmCRPC) or B.) Metastatic hormone-sensitive prostate cancer in combination with docetaxel. For treatment of nmCRPC, one of the following applies 1.) Used in combination with a gonadotropin-releasing hormone (GnRH) analog or 2) Patient has received bilateral orchiectomy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Severe asthma with eosinophilic phenotype and used as an adjunct treatment, B.) Eosinophilic granulomatosis with polyangiitis (EGPA), C.) Hypereosinophilic syndrome lasting at least 6 months without an identifiable non-hematologic secondary cause, or D.) Chronic rhinosinusitis with nasal polyps and used as an adjunct treatment
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes, B.) Heart failure, C.) Complete AV block without an implanted pacemaker or high risk of complete AV block, D.) Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), E.) Concomitant use with MAOIs or within 14 days of MAOI therapy, F.) History of quinine-, mefloquine-, or quinidine-induced thrombocytopenia, bone marrow depression, or lupus-like syndrome
Required Medical Information	Diagnosis of pseudobulbar affect
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Parkinson's disease and both of the following apply A.) Used for treatment of hallucinations and/or delusions associated with Parkinson's disease psychosis, and B.) Diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OCREVUS ZUNOVO

Products Affected

- OCREVUS ZUNOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Acromegaly confirmed by high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range and patient has had inadequate response to or is ineligible for surgery, radiation, or bromocriptine mesylate, or B.) Metastatic carcinoid syndrome with associated diarrhea or flushing, or C.) Vasoactive intestinal peptide-secreting tumors (VIPomas) with associated diarrhea
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma of the skin and one of the following A.) Cancer has recurred following surgery or radiation therapy, B.) Patient is not a candidate for surgery or radiation therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Idiopathic pulmonary fibrosis (IPF), B.) Systemic sclerosis-associated interstitial lung disease (ILD), or C.) Chronic fibrosing interstitial lung disease with a progressive phenotype
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OGSIVEO

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OJEMDA

Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OJJAARA

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ONUREG

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute myeloid leukemia (AML) used in maintenance treatment for adult patients who achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I), confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORGOVYX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORSERDU

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic, ER-positive, HER2-negative, ESR1-mutated, breast cancer in postmenopausal women or adult men after at least 1 line of endocrine therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Undiagnosed abnormal genital bleeding, B.) Known or suspected estrogen-dependent neoplasia, C.) Active deep vein thrombosis (DVT), pulmonary embolism (PE), or a history of these conditions, D.) Active arterial thromboembolic disease (e.g. stroke, myocardial infarction) or a history of these conditions, or E.) Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause, or B.) Moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A.) Active psoriatic arthritis and patient has trial and failure or intolerance or contraindication to two preferred products, (i.e. Humira, Enbrel, Rinvoq, Skyrizi, Stelara), B.) Moderate to severe plaque psoriasis, patient is a candidate for phototherapy or systemic therapy, and patient has trial and failure or intolerance or contraindication to two preferred products, (i.e. Humira, Enbrel, Skyrizi, Stelara), C.) Mild plaque psoriasis, patient is a candidate for phototherapy or systemic therapy, and patient has trial and failure or intolerance or contraindication to at least one topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analog), or D.) Behcet's Disease and patient has active oral ulcers
Age Restrictions	6 years of age and older
Prescriber Restrictions	PsA: Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis: Prescribed by or in consultation with a dermatologist.
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OXLUMO

Products Affected

- OXLUMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PANRETIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of AIDS-related Kaposi's sarcoma and both of the following 1.) Used to treat cutaneous lesions, and 2.) Systemic anti-Kaposi's Sarcoma therapy is not indicated (e.g., patient does not have more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or HIV specialist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PEGYLATED INTERFERON

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Autoimmune hepatitis, B.) Hepatic decompensation (Child-Pugh score greater than 6 (Class B and C) in cirrhotic patients before treatment, OR hepatic decompensation (Child-Pugh score greater than or equal to 6) in cirrhotic patients co-infected with hepatitis C and HIV before treatment, C.) Hypersensitivity reactions, including urticaria, bronchoconstriction, anaphylaxis, or Stevens-Johnson syndrome to alfa interferons or any component of the product, or D.) Pregnancy with concomitant ribavirin use
Required Medical Information	Diagnosis of one of the following A.) Chronic hepatitis B infection, or B.) Chronic hepatitis C and required criteria will be applied consistent with current AASLD-IDSA guidance with compensated liver disease
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PEMAZYRE

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with confirmed fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or B.) Relapsed or refractory myeloid/lymphoid neoplasms with fibroblast growth factor receptor 1 rearrangement
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, gastroenterologist, or hepatologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PIQRAY

Products Affected

- PIQRAY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR) positive, HER2-negative, PIK3CA-mutated, advanced or metastatic breast cancer and must meet all of the following 1.) Used in combination with fulvestrant, 2.) Disease has progressed on or after an endocrine-based regimen, and 3.) Patient is a male or postmenopausal female
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PIRFENIDONE

Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following A.) AIDS-related Kaposi sarcoma and patient has failure on highly active antiretroviral therapy (HAART), B.) Kaposi sarcoma in HIV-negative adults, or C.) Multiple myeloma and in combination with dexamethasone in adults who have received at least 2 prior therapies (including lenalidomide and a proteasome inhibitor) and have demonstrated disease progression on or within 60 days of completion of the last therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

POSACONAZOLE

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
Required Medical Information	Diagnosis of one of the following A.) Oropharyngeal candidiasis, B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection, or C.) Invasive aspergillosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

POSACONAZOLE SUSPENSION

Products Affected

- NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON
- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
Required Medical Information	Diagnosis of one of the following A.) Oropharyngeal candidiasis, B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection, or C.) Invasive aspergillosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant use with pimozide or ergot alkaloids (ergotamine, dihydroergotamine), B.) Concomitant use with pitavastatin or simvastatin when coadministered with cyclosporine
Required Medical Information	One of the following A.) Patient is CMV-seropositive (R+) and is receiving an allogeneic hematopoietic stem cell transplant (HSCT), or B) CMV prophylaxis in a high risk kidney transplant recipient
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROMACTA

Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic idiopathic thrombocytopenic purpura (ITP), B.) Chronic hepatitis C infection associated thrombocytopenia, or C.) Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with standard immunosuppressive therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QINLOCK

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced gastrointestinal stromal tumor (GIST) and patient has received prior treatment with 3 or more kinase inhibitors, including imatinib
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QUININE SULFATE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Prolongation of QT interval, B.) Glucose-6-phosphate dehydrogenase deficiency, C.) Myasthenia gravis, D.) Known hypersensitivity to mefloquine or quinidine, E.) Optic neuritis, F.) Diagnosis of Blackwater fever, G.) Use solely for treatment or prevention of nocturnal leg cramps
Required Medical Information	Diagnosis of one of the following A.) uncomplicated Plasmodium falciparum malaria, B.) uncomplicated Plasmodium vivax malaria, or C.) babesiosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of urea cycle disorders
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	Known neoplasm at the site of application
Required Medical Information	Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH), B.) homozygous familial hypercholesterolemia, C.) established cardiovascular disease and myocardial infarction prophylaxis, stroke prophylaxis, or coronary revascularization prophylaxis is required, or D.) clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following 1.) acute coronary syndrome, 2.) history of myocardial infarction, 3.) stable/unstable angina, 4.) coronary or other arterial revascularization, 5.) stroke, 6.) transient ischemic stroke (TIA), or 7.) peripheral arterial disease presumed to be atherosclerotic region
Age Restrictions	10 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RETEVMO

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in patients who require systemic therapy, B.) Metastatic RET fusion-positive non-small cell lung cancer (NSCLC), C.) Advanced or metastatic RET fusion-positive thyroid cancer in patients who require systemic therapy and are refractory to radioactive iodine, if appropriate, or D.) Locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REZLIDHIA

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a susceptible IDH1 mutation as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic graft-vs-host disease and patient has failed at least 2 prior lines of systemic therapy.
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RILUZOLE

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ
- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

ROZLYTREK

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) ROS1-positive metastatic non-small cell lung cancer (NSCLC), or B.) Solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have either progressed following treatment or have no satisfactory alternative therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, used as maintenance treatment, and patient is in complete or partial response to platinum-based chemotherapy, or B.) Deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer and patient has been treated with androgen receptor-directed therapy and a taxane-based chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation therapy, or B.) systemic mastocytosis or mast cell leukemia
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RYTELO

Products Affected

- RYTELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SAPROPTERIN

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 2 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SCEMBLIX

Products Affected

- SCEMBLIX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs), or B.) Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) with the T315I mutation
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Cushing disease and patient has had inadequate response to or is not a candidate for surgery. For renewal: Documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels or improvement in signs or symptoms of the disease
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SILDENAFIL

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Nitrate therapy, including intermittent use, B.) Concomitant use with riocguat or other guanylate cyclase stimulators, C.) Concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I), confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Must meet all of the following 1.) Diagnosis of pulmonary multidrug resistant tuberculosis (MDR-TB) and 2.) Used in combination with at least 3 other antibiotics for the treatment of pulmonary multi-drug resistant tuberculosis
Age Restrictions	5 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	24 weeks
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SKYRIZI

Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe plaque psoriasis and patient is a candidate for systemic therapy or phototherapy, B.) Active psoriatic arthritis, or C.) Moderately to severely active Crohn's disease
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SODIUM OXYBATE

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant treatment with sedative hypnotic agents, B.) Succinic semialdehyde dehydrogenase deficiency
Required Medical Information	Diagnosis of one of the following A.) Narcolepsy with excessive daytime drowsiness and has trial of/or contraindication to a central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate) or a CNS wakefulness promoting drug (e.g., armodafinil, modafinil), or B.) Cataplexy and narcolepsy
Age Restrictions	7 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOLTAMOX

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant coumarin-type anticoagulant therapy, B.) history of thromboembolic disease such as DVT or PE
Required Medical Information	Diagnosis of breast cancer and documentation of inability to swallow tablet formulation
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOMATULINE DEPOT

Products Affected

- *lanreotide subcutaneous syringe 60 mg/0.2 ml, 90 mg/0.3 ml*
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS. GEPNETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of acromegaly confirmed by high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range and patient has had an inadequate response to or is ineligible for surgery or radiation therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SORAFENIB

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	Squamous cell lung cancer being treated with carboplatin and paclitaxel
Required Medical Information	Diagnosis of one of the following A.) Advanced renal cell carcinoma, B.) Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment, or C.) Unresectable hepatocellular carcinoma
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SPRYCEL

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, B.) Chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy, C.) Ph+ acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy, or D.) Newly diagnosed Ph+ ALL in combination with chemotherapy
Age Restrictions	1 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severely active Crohn disease, B.) Moderate to severe plaque psoriasis, C.) Active psoriatic arthritis, or D.) Moderate to severe active ulcerative colitis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic colorectal cancer in patients previously treated with fluoropyrimidine, oxaliplatin, and irinotecan containing chemotherapy, anti-VEGF therapy, and if RAS wild type, anti-EGFR therapy, B.) Liver carcinoma in patients previously treated with sorafenib, or C.) Locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with imatinib and sunitinib
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SUNITINIB

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Gastrointestinal stromal tumor after disease progression on or intolerance to imatinib, B.) Pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease, C.) Advanced renal cell carcinoma, or D.) Renal cell carcinoma and used as adjuvant therapy following nephrectomy in patients who are at high risk for recurrence
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis (CF) and must meet one of the following 1.) Patient is homozygous for the F508del mutation, or 2.) Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
Age Restrictions	6 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	Initial: 6 months, Renewal: 12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Confirmed diagnosis of gastroparesis, B.) Hypoglycemia unawareness
Required Medical Information	Diagnosis of type 1 or type 2 diabetes mellitus and patient uses mealtime insulin therapy and has failed to achieve desired glucose control
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) pregnancy, B.) breastfeeding, C.) undiagnosed abnormal vaginal bleeding
Required Medical Information	Diagnosis of one of the following A.) Central precocious puberty, or B.) Endometriosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML) and patient has tried and failed or has a contraindication or intolerance to at least 2 tyrosine kinase inhibitors
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TABLOID

Products Affected

- TABLOID

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute myeloid leukemia (induction and consolidation therapy only)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TABRECTA

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAFINLAR

Products Affected

- TAFINLAR ORAL CAPSULE 50 MG, 75 MG
- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Locally advanced or metastatic anaplastic thyroid carcinoma with BRAF V600E mutation, in combination with trametinib and no satisfactory locoregional treatment options, B.) Metastatic non-small cell lung cancer with BRAF V600E mutation, in combination with trametinib OR in patients previously treated as monotherapy, C.) Unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutation, D.) Unresectable or metastatic solid tumors with BRAF V600E mutation, in combination with trametinib, and have progressed following prior treatment and have no satisfactory alternative treatment options, or E.) Low-grade glioma with a BRAF V600E mutation and require systemic therapy, in combination with trametinib
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletion or exon 21 L858R mutation and used as first line therapy, B.) Metastatic non-small cell lung cancer with T790M EGFR mutation (as confirmed by an FDA-approved test) AND whose disease has progressed on or after EGFR tyrosine kinase inhibitor therapy, or C.) Non-small cell lung cancer (NSCLC) with tumor epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations (as confirmed by an FDA-approved test) AND patient requires adjuvant therapy after tumor resection
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following and used as routine prophylaxis A.) Hereditary angioedema (HAE) with C1 inhibitor deficiency (Type 1) confirmed by laboratory testing, or B.) HAE with C1 inhibitor dysfunction (Type 2) confirmed by laboratory testing, or C.) HAE with normal C1 inhibitor (Type 3) confirmed by laboratory testing and one of the following 1.) Positive test for an F12, angiopoietin-1, or plasminogen gene mutation, or 2.) Family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, immunologist, or allergist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: COSENTYX, ENBREL, HUMIRA, STELARA, SKYRIZI, TREMFYA, OTEZLA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, ENBREL, HUMIRA, STELARA, XELJANZ, RINVOQ, SKYRIZI, TREMFYA, OTEZLA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, COSENTYX, XELJANZ, RINVOQ. NR-AXSPA: 1) TRIAL OF OR CONTRAINDICATION TO BOTH OF THE PREFERRED AGENTS: COSENTYX, RINVOQ, OR 2) TRIAL OF COSENTYX AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: PSO, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TALVEY

Products Affected

- TALVEY

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TALZENNA

Products Affected

- TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm), human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer, or B) homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC) in combination with enzalutamide
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Long QT syndrome, B.) Uncorrected hypokalemia, C.) Uncorrected hypomagnesemia
Required Medical Information	Diagnosis of one of the following A.) Newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML), B.) Chronic phase or accelerated phase Philadelphia chromosome-positive CML in a patient with resistance or intolerance to prior therapy that included imatinib, or C.) Chronic phase Philadelphia chromosome-positive CML in a patient with resistance or intolerance to prior tyrosine-kinase inhibitor therapy
Age Restrictions	1 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) and both of the following apply 1.) Used as adjunctive treatment, and 2.) Used in combination with standard therapy including glucocorticoids
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAZAROTENE

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*
- TAZORAC TOPICAL CREAM 0.05 %

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Acne vulgaris and patient has trial with at least one generic topical acne product, or B.) Stable moderate to severe plaque psoriasis with 20% or less body surface area involvement and patient has trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs)
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAZVERIK

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic or locally advanced epithelioid sarcoma in patients not eligible for complete resection, B.) Relapsed or refractory follicular lymphoma in patients whose tumors are positive for an EZH2 mutation as detected by an FDA-approved test and who have received at least 2 prior systemic therapies, or C.) Relapsed or refractory follicular lymphoma in patients who have no satisfactory alternative treatment options
Age Restrictions	16 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEGSEDI

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Platelet count less than 100,000 per microliter, B.) Urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
Required Medical Information	Diagnosis of Polyneuropathy of hereditary transthyretin-mediated amyloidosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEPMETKO

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Osteoporosis in postmenopausal female patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate or Tymlos, B.) Primary or hypogonadal osteoporosis in male patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate, or C.) Osteoporosis due to associated sustained systemic glucocorticoid therapy in patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months, Renewal: 12 months (Maximum 24 month treatment per patient lifetime)
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TETRABENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Actively suicidal, B.) Untreated or inadequately treated depression, C.) Impaired hepatic function, D.) Concomitant use of monoamine oxidase inhibitors, E.) Concomitant use of reserpine or within 20 days of discontinuing reserpine
Required Medical Information	Diagnosis of chorea associated with Huntington's disease
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEVIMBRA

Products Affected

- TEVIMBRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

THALOMID

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following A.) Multiple myeloma that is newly diagnosed, or B.) Erythema nodosum leprosum (ENL)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, infectious disease specialist, or dermatologist.
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsed or refractory acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 mutation (as detected by an FDA-approved test), B.) Previously treated, locally advanced or metastatic cholangiocarcinoma with an isocitrate dehydrogenase-1 mutation (as detected by an FDA-approved test.), or C.) Acute myeloid leukemia (newly-diagnosed) with susceptible isocitrate dehydrogenase-1 mutation and meets one of the following: 1.) Patient is 75 years of age or older, or 2.) Patient has comorbidities that preclude intensive induction chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hematologist, hepatologist, or oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TOBI

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	Known sensitivity to any aminoglycoside
Required Medical Information	Diagnosis of cystic fibrosis (confirmed by appropriate diagnostic or genetic testing) and patient has suspected or confirmed Pseudomonas aeruginosa infection in the lungs
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.
Other Criteria	INITIAL: RA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR, RINVOQ. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR, RINVOQ. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOLVAPTAN

Products Affected

- *tolvaptan oral tablet 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Diagnosis of Autosomal Dominant Polycystic Kidney Disease (ADPKD), B.) Urgent need to raise serum sodium acutely, C.) Inability to sense or appropriately respond to thirst, D.) Hypovolemic hyponatremia, E.) Concomitant use of strong CYP 3A Inhibitors (e.g. clarithromycin, ketoconazole, ritonavir), or F.) Anuria
Required Medical Information	Diagnosis of clinically significant hypervolemic or euvolemic hyponatremia (serum sodium less than 125 mEq/L or less marks hyponatremia that is symptomatic and has resisted correction with fluid restriction), including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TOPICAL RETINOIDS

Products Affected

- *avita topical gel*
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate acne vulgaris
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TOREMIFENE

Products Affected

- *toremifene*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Acquired or congenital long QT syndrome, B.) Uncorrected hypokalemia, C.) Uncorrected hypomagnesemia
Required Medical Information	Diagnosis of metastatic breast cancer and patient must have previous inadequate response or intolerance to tamoxifen
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced prostate cancer
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TREMFYA

Products Affected

- TREMFYA PEN
- TREMFYA SUBCUTANEOUS SYRINGE 200 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval
Part B Prerequisite	No

TRIENTINE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Wilson's disease in patients that are intolerant to penicillamine
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRIKAFTA

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis (CF) and patient has at least 1 F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive to elexacaftor/tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRUQAP

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TUKYSA

Products Affected

- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A.) advanced unresectable or metastatic HER2-positive breast cancer (including brain metastases) in patients who have received one or more prior anti-HER2-based regimens in the metastatic setting and drug is being used in combination with trastuzumab and capecitabine, or B.) unresectable or metastatic RAS wild-type, HER2-positive colorectal cancer that has progressed following treatment with fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy and drug is being used in combination with trastuzumab
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of osteoporosis in men or postmenopausal women and one of the following A.) osteoporotic fracture or multiple risk factors for fracture, or B.) previous trial of/or contraindication to bisphosphonate
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months, Renewal: 12 months (Maximum 24 month treatment per patient lifetime)
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)
Required Medical Information	Diagnosis of migraine disorder with or without aura and patient has documented trial, inadequate response, or contraindication to at least 1 generic formulary triptan
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma (stage IA and IB mycosis fungoides-type) and patient has received prior skin-directed therapy (e.g. Topical corticosteroids, phototherapy, or topical nitrogen mustard)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VANFLYTA

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	12 MONTHS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A inhibitor during the initial and titration phase in patients with CLL or SLL
Required Medical Information	Diagnosis of one of the following A.) chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), or B.) Newly-diagnosed acute myeloid leukemia (AML) and used in combination with azacitidine, decitabine or low-dose cytarabine in patients 75 years or older or who have comorbidities that preclude use of intensive induction chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant use of other soluble guanylate cyclase (sGC) stimulators, or B.) Pregnancy
Required Medical Information	Diagnosis of chronic heart failure (HF), NYHA Class II to IV and all of the following 1.) Left ventricular ejection fraction less than 45%, 2.) Previous hospitalization for HF within 6 months or outpatient IV diuretic treatment for HF within 3 months
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer and ALL of the following: 1.) Patient is at high risk of recurrence, and 2.) Requested drug will be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for adjuvant treatment, OR B.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer and one of the following 1.) Used in combination with fulvestrant in a patient with disease progression following endocrine therapy, 2.) Used as monotherapy in a patient with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting, or 3.) Used as initial endocrine-based treatment in combination with an aromatase inhibitor
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VIGABATRIN

Products Affected

- *vigabatrin*
- *vigadrone oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Infantile spasms, or B.) Refractory complex partial seizures and the drug is being used as adjunctive therapy in patients who have responded inadequately to two alternative treatments
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VIJOICE

Products Affected

- VIJOICE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) in patients who require systemic therapy
Age Restrictions	2 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VITRAKVI

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic or surgically unresectable neurotrophic receptor tyrosine kinase (NTRK) gene fusion positive solid tumors without a known acquired resistance mutation and used in patients with unsatisfactory alternative treatments or who have progressed following treatment
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer with confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VONJO

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of intermediate or high-risk primary or secondary myelofibrosis in adults AND a platelet count less than 50 X 10(9)/L
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VORANIGO

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VORICONAZOLE

Products Affected

- *voriconazole*

PA Criteria	Criteria Details
Exclusion Criteria	Any of the following A.) Concomitant use of carbamazepine, CYP3A4 substrates (e.g., terfenadine, astemizole, cisapride, pimozide, or quinidine), B.) Concomitant use with high-dose ritonavir (400mg every 12 hours), C.) Concomitant use with ergot alkaloids, D.) Concomitant use with long-acting barbiturates, E.) Conc0mitant use with rifabutin or rifampin, F.) Concomitant use with sirolimus, or G.) Concomitant use with efavirenz at standard doses of 400mg/day or higher
Required Medical Information	Diagnosis of one of the following A.) Invasive aspergillosis, B.) Candidemia, C.) Esophageal Candidiasis, D.) Invasive candidiasis of the skin and abdomen, kidney, bladder wall, and wounds, or E.) Serious fungal infection due to Scedosporium apiospermum or Fusarium species
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	6 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VOTRIENT

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced renal cell carcinoma, or B.) Advanced soft tissue sarcoma and patient received at least one prior chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VYALEV

Products Affected

- VYALEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PD: INITIAL: 1) RESPONSIVE TO LEVODOPA, 2) CURRENT REGIMEN INCLUDES AT LEAST 400 MG/DAY OF LEVODOPA, AND 3) MOTOR SYMPTOMS ARE CURRENTLY UNCONTROLLED (DEFINED AS AN AVERAGE OFF TIME OF AT LEAST 2.5 HOURS/DAY OVER 3 CONSECUTIVE DAYS WITH A MINIMUM OF 2 HOURS EACH DAY). RENEWAL: IMPROVEMENT IN MOTOR SYMPTOMS WHILE ON THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VYNDAMAX

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of wild type or hereditary transthyretin related familial amyloid cardiomyopathy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

WELIREG

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of von Hippel-Lindau (VHL) disease and therapy is required for any of the following disease associated tumors that do not require immediate surgery A.) Renal cell carcinoma (RCC), B.) Central nervous system (CNS) hemangioblastoma, or C.) Pancreatic neuroendocrine tumor (pNET)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

WINREVAIR

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND 3) PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 2 WOOD UNITS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS.
Other Criteria	PAH: INITIAL: 1) ON BACKGROUND PAH THERAPY (FOR AT LEAST 3 MONTHS) WITH AT LEAST TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: A) ORAL ENDOTHELIN RECEPTOR ANTAGONIST, B) ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR FOR PAH, C) ORAL CGMP STIMULATOR, D) IV/SQ PROSTACYCLIN, OR 2) ON ONE AGENT FROM ONE OF THE ABOVE DRUG CLASSES, AND HAS A CONTRAINDICATION OR INTOLERANCE TO ALL OF THE OTHER DRUG CLASSES.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XALKORI

Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive or ROS1-positive as detected by an FDA-approved test, B.) Relapsed or refractory systemic anaplastic large cell lymphoma that is anaplastic lymphoma kinase (ALK) positive as detected by an FDA-approved test, or C.) Unresectable, recurrent, or refractory inflammatory myofibroblastic tumors that are anaplastic lymphoma kinase (ALK)-positive
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Hypocalcemia (calcium less than 8.0 mg/dL)
Required Medical Information	Diagnosis of one of the following A.) Bone metastases from a solid tumor and used for the prevention of skeletal related events, B.) Multiple myeloma and used for the prevention of skeletal related events, C.) Hypercalcemia of malignancy refractory to bisphosphonate therapy, or D.) Giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chronic idiopathic urticaria in patients who remain symptomatic despite H1 antihistamine therapy and patient will continue to receive concurrent H1 antihistamine therapy unless contraindicated or not tolerated, B.) Moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms are inadequately controlled with inhaled corticosteroids and an additional controller medication (i.e. long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) and patient has trial and failure, contraindication, or intolerance to Dupixent or Nucala, C.) Nasal polyps in patients with inadequate response to nasal corticosteroids, requested drug will be used as adjunctive treatment, and patient has trial and failure, contraindication, or intolerance to Dupixent or D.) Allergy to food, IgE-mediated allergic reaction
Age Restrictions	
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XPOVIO

Products Affected

- XPOVIO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Relapsed or refractory multiple myeloma being used in combination with dexamethasone in a patient who has received at least 4 prior therapies and is refractory to at least 2 proteasome inhibitors, at least 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody, B.) Multiple myeloma being used in combination with bortezomib and dexamethasone in a patient who has received at least 1 prior therapy, C.) Relapsed or refractory diffuse large B-cell lymphoma not otherwise specified, or D.) Relapsed or refractory DLBCL arising from follicular lymphoma and patient has received at least 2 lines of systemic therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XTANDI

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Castration-resistant prostate cancer (CRPC) or B.) Metastatic, castration-sensitive prostate cancer (mCSPC). For treatment of CRPC and mCSPC, one of the following applies 1.) Used in combination with a gonadotropin-releasing hormone (GnRH) analog or 2) Patient has received bilateral orchiectomy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary orotic aciduria
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of metastatic, castration-resistant prostate cancer (mCRPC) and used in combination with methylprednisolone. For treatment of mCRPC, one of the following applies: 1.) Used in combination with a gonadotropin-releasing hormone (GnRH) analog or 2) Patient has received bilateral orchiectomy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZARXIO

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Chemotherapy induced febrile neutropenia (prophylaxis), B.) Severe chronic neutropenia, C.) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, or D.) Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZEJULA

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer and used as maintenance therapy in a patient who is in a complete or partial response to platinum-based chemotherapy, or B.) Deleterious or suspected deleterious germline BRCA-mutated (gBRCAmut) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and used as maintenance treatment in a patient who is in a complete or partial response to platinum-based chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation documented by an FDA-approved test, or B.) Erdheim-Chester disease and patient has documented BRAF V600 mutation
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZIEXTENZO

Products Affected

- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of a non-myeloid malignancy and drug is being used as prophylaxis for chemotherapy-induced neutropenia
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZOKINVY

Products Affected

- ZOKINVY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Hutchinson-Gilford Progeria Syndrome or B.)Processing deficient progeroid laminopathy with documentation of either heterozygous LMNA mutation with progerin-like protein accumulation or homozygous or compound heterozygous ZMPSTE24 mutations
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of primary cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent or recurrent disease on or following two systemic therapies (e.g., bexarotene, romidepsin, etc)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZURZUVAE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	14 DAYS
Other Criteria	NONE
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	History of toxic epidermal necrosis with any drug
Required Medical Information	Diagnosis of Chronic lymphocytic leukemia, used in combination with rituximab and patient has relapsed on at least one prior therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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