ABIRATERONE

Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega
- Yonsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ACTEMRA (TOCILIZUMAB)

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Lung disease with systemic sclerosis, renewal: documentation of a reduction in decline in pulmonary function. 3) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Temporal arteritis, renewal: documentation of clinical benefit or remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: pulmonologist for lung disease, rheumatologist for RA, JIA, and temporal arteritis.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	pJIA initial: failure of an 8 week trial of methotrexate.RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ACTHAR HP (CORTICOTROPIN)

Products Affected

- Acthar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use of corticotropin intravenously. Cortictropin should not be used in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpex simplex, recent surgery, history of or active peptic ulcer disease, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin. Corticotropin is contraindicated in patients under the age of 2 with suspected congenital infections and for patients who also have adrenocortical insufficiency or adrenocortical hyperfunction.
Required Medical Information	Medical record documentation of one of the following conditions: 1) Infantile spasms, 2) Acute exacerbation of multiple sclerosis, 3) Exacerbation of rheumatic disorders including psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, 4) Exacerbation of or maintenance for collagen diseases including systemic lupus erythematosus, systemic dermatomyositis, 5) Dermatologic diseases including severe erythema multiforme, Stevens-Johnson Syndrome, 6) Allergic states such as serum sickness, 7) Ophthalmic diseases including keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, 8) Respiratory diseases such as symptomatic sarcoidosis or 9) Edematous condition from nephrotic syndrome or lupus erythematosus.
Age Restrictions	For infantile spasms: 2 years of age or younger
Prescriber Restrictions	N/A
Coverage Duration	Infantile spasms: until two years of age. All others: 1 month.
Other Criteria	For steroid responsive conditions, conditions number 2 to 7 listed in the Required Medical Information section: medical record documentation of failure of corticosteroid therapy in the last 30 days or reason why corticosteroids cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ACTIMMUNE (INTERFERON GAMMA-1B)

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	T-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Prior authorization criteria does not apply to members already established on Actimmune for the treatment of T-cell lymphoma. 1. The use of Actimmune for T-cell lymphoma must be supported by Micromedex, AHFS-Drug Information, NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, or acceptable medical journals.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADALIMUMAB BIOSIMILARS

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter
- Adalimumab-adbm

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ADBRY (TRALOKINUMAB-LDRM)

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AGAMREE (VAMOROLONE)

Products Affected

- Agamree

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AIMOVIG (ERENUMAB-AOOE)

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AKEEGA (NIRAPARIB-ABIRATERONE)

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALECENSA (ALECTINIB)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALOSETRON

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Constipation. 2) Intestinal obstruction, stricture, toxic megacolon, GI perforation and/or adhesions. 3) Ischemic colitis, impaired intestinal circulation. 4) Severe hepatic impairment. 5) Diverticulitis. 6) Hypercoaguable state. 6) Thrombophlebitis. 7) Crohn's disease or ulcerative colitis. 8) Concomitant use with apomorphine or fluvoxamine.
Required Medical Information	Initial: Medical record documentation of predominant symptom is severe diarrhea lasting at least 6 months and defined as frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, or disability or restriction of daily activities due to IBS. Renewal: Medical record documentation of a significant reduction in diarrhea frequency and abdominal pain and/or improvement in quality of life during the 8 week trial.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 8 weeks. Renewal: Lifetime.
Other Criteria	Failure of loperamide and dicyclomine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ALUNBRIG (BRIGATINIB)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALYFTREK (VANZACAFTOR-TEZACAFTOR-DEUTIVACAFTOR)

Products Affected

- Alyftrek

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AMBRISENTAN

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy
Required Medical Information	Documentation of WHO functional Class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ANZUPGO (DELGOCITINIB)

Products Affected

- Anzupgo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Documentation of hand eczema persisting for longer than 3 months, or recurring at least 2 times within 12-month time frame.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Inadequate response, intolerance, or contraindication to at least one moderate to high potency topical corticosteroid, OR documentation showing that topical corticosteroids are not advisable.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

APOMORPHINE

Products Affected

- Apomorphine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AQNEURSA (LEVACETYLLEUCINE)

Products Affected

- Aqneursa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: a) confirmation of a diagnosis of Niemann-Pick disease type C (NPC) by genetic testing, b) documentation of neurologic symptoms due to NPC, and c) documentation of weight at least 15kg.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist or neurologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AQVESME (MITAPIVAT)

Products Affected

- Aqvesme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: confirmation of a diagnosis of alpha or beta thalassemia via genetic testing. Renewal: documentation of clinical benefit, such as improvement in anemia or reduction in iron overload.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For transfusion-dependent beta thalassemia only: Failure of or contraindication to Ryblozyl.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARALAST (ALPHA1-PROTEINASE INHIBITOR)

Products Affected

- Aralast Np INJ 1000MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) documented ZZ or Z/null AAT deficiency and 2) AAT serum level less than or equal to 11 micromoles/L or 50mg/dL and 3) moderate emphysema and/or FEV1 less than 80% and 4) the provider has outlined specific, measurable treatment goals such as slowing of FEV1 decline or lack of disease progression. Renewal: documentation patient is meeting treatment goals such as slowing FEV1 decline or lack of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARCALYST (RILONACEPT)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AREXVY (RSV VACCINE)

Products Affected

- Arexvy

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARIKAYCE (AMIKACIN)

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARISTADA (ARIPIPRAZOLE LAUROXIL IM)

Products Affected

- Aristada
- Aristada Initio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The following criteria applies to members who newly start on the drug: documentation that the patient is currently taking oral aripiprazole and prescriber wishes to switch to the injection to improve compliance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ATTRUBY (ACORAMIDIS)

Products Affected

- Attruby

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation confirming the diagnosis of either wild-type or hereditary transthyretin amyloid cardiomyopathy (ATTRwt-CM or hATTR-CM).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUGTYRO (REPOTRECTINIB)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUSTEDO (DEUTETRABENAZINE)

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AUVELITY (DEXTROMETHORPHAN-BUPROPION)

Products Affected

- Auvelity TBCR 105MG; 45MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AVMAPKI (AVUTOMETINIB-DEFACTINIB)

Products Affected

- Avmapki Fakzynja Co-pack

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AYVAKIT (AVAPRITINIB)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gastroenterologist for gastrointestinal stromal tumor, or an allergist or immunologist for systemic mast cell disease.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BALVERSA (ERDAFITINIB)

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENLYSTA (BELIMUMAB)

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BENZNIDAZOLE

Products Affected

- Benznidazole

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Chagas disease caused by T. cruzi confirmed by detection of T. cruzi trypomastigotes on microscopy, detection of T. cruzi DNA by PCR assay, or 2 positive diagnostic serologic tests using two different techniques and antigens showing IgG antibodies to T. cruzi.
Age Restrictions	Between 2 years and 12 years of age
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or cardiologist.
Coverage Duration	60 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BESREMI (ROPEGINTERFERON ALFA-2B-NJFT)

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BETAINE POWDER

Products Affected

- Betaine Anhydrous

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEXAROTENE

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, dermatologist, or infectious disease specialist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BEXSERO (MENINGOCOCCAL B VACCINE)

Products Affected

- Bexsero INJ 0.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Between 10 years and 25 years of age
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BOSENTAN

Products Affected

- Bosentan

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BOSULIF (BOSUTINIB)

Products Affected

- Bosulif CAPS
- Bosulif TABS 100MG, 500MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BOSUTINIB

Products Affected

- Bosutinib TABS 400MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BRAFTOVI (ENCORAFENIB)

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRINSUPRI (BRENSOCATIB)

Products Affected

- Brinsupri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: confirmation of a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by CT scan. Renewal: medical record documentation of clinical benefit, such as reduction in exacerbations, fatigue, malaise or breathlessness, or improved exercise tolerance.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRIVARACETAM

Products Affected

- Brivaracetam SOLN
- Brivaracetam TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BRUKINSA (ZANUBRUTINIB)

Products Affected

- Brukinsa TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BUPRENORPHINE PATCH

Products Affected

- Buprenorphine PTWK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of morphine sulfate ER.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CABLIVI (CAPLACIZUMAB-YHDP)

Products Affected

- Cablivi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Medical record support of a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP). 2) Documentation that Cablivi will be used in combination with plasma exchange. Renewal: Documented signs of persistent underlying disease such as suppressed ADAMTS13 activity levels remain present.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 90 days. Renewal-receiving plasma exchange: 90 days. Renewal-post plasma exchange: 58 days.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CABOZANTINIB

Products Affected

- Cabometyx
- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CALQUENCE (ACALABRUTINIB)

Products Affected

- Calquence TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CAMZYOS (MAVACAMTEN)

Products Affected

- Camzyos

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CAPLYTA (LUMATEPERONE)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: 1) For treatment of schizophrenia: failure of two of the following: lurasidone, Rexulti, Vraylar, Fanapt (requires step therapy for new starts). 2) For treatment of depressive episodes associated with bipolar I or II disorder (bipolar depression): failure of two of the following: lithium, divalproex sodium, lurasidone, quetiapine or olanzapine. 3) For adjunctive therapy with antidepressants for the treatment of major depressive disorder: failure of aripiprazole or quetiapine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPRELSA (VANDETANIB)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CARBAGLU (CARGLUMIC ACID)

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CARDAMYST (ETRIPAMIL)

Products Affected

- Cardamyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) NYHA Class II-IV heart failure. 2) Wolff-Parkinson-White syndrome, Lown-Ganon-Levine syndrome, or sick sinus syndrome without a permanent pacemaker. 3) second degree atrioventricular (AV) Mobitz 2 block or higher degree AV block.
Required Medical Information	Initial: Confirmation of a diagnosis of paroxysmal supraventricular tachycardia (PSVT) and documentation of a history of symptomatic episodes of PSVT. Renewal: Medical record documentation of reduction in symptoms or cessation of PSVT episode after taking the drug.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or electrophysiologist.
Coverage Duration	Initial: 12 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CAYSTON (AZTREONAM LYSINE)

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of 1) FEV1 between 25% and 90% predicted and 2) Pseudomonas aeruginosa infection.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or infectious disease specialist.
Coverage Duration	12 months
Other Criteria	Documentation of failure of or resistance to tobramycin (TOBI).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CERDELGA (ELIGLUSTAT)

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CHOLBAM (CHOLIC ACID)

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Bile acid synthesis defect, initial: medical record documentation of a bile acid synthesis disorder. First renewal after 4 months of initiating treatment: medical record documentation of liver function improvement and lack of complete biliary obstruction. Ongoing renewal criteria: lack of complete biliary obstruction. 2) Peroxisomal disorders, initial: Medical record documentation that Cholbam will be used adjunctively, and that there are liver disease manifestations, steatorrhea, or complications due to decreased absorption of fat soluble vitamins. First renewal after 4 months of initiating treatment: medical record documentation of liver function improvement and lack of complete biliary obstruction. Ongoing renewal criteria: lack of complete biliary obstruction.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Initial: 4 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CIMZIA (CERTOLIZUMAB PEGOL)

Products Affected

- Cimzia
- Cimzia (1 Syringe)
- Cimzia (2 Syringe)
- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

CITALOPRAM 40MG

Products Affected

- Citalopram Hydrobromide TABS 40MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not covered for members age 60 years or older who newly start on citalopram and using more than 20mg of citalopram per day.
Required Medical Information	N/A
Age Restrictions	Prior Authorization applies to members who newly start on citalopram and are 60 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CLOBAZAM

Products Affected

- Clobazam SUSP 2.5MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COBENFY (XANOMELINE-TROSPIUM)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of schizophrenia.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug. Failure of two of the following: lurasidone, aripiprazole, risperidone, olanzapine, quetiapine, ziprasidone.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COPIKTRA (DUVELISIB)

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CORLANOR (IVABRADINE)

Products Affected

- Ivabradine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Adults with chronic heart failure: medical record documentation of the following: 1) Ejection fraction of 35% or less and 2) In sinus rhythm with a resting heart rate of at least 70 beats per minute.
Age Restrictions	Stable symptomatic heart failure due to dilated cardiomyopathy (DCM): between 6 months and 19 years of age
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) Receiving maximally tolerated doses of a beta blocker or there is a medical reason why a beta blocker cannot be used and 2) failure of a) an angiotensin receptor enzyme inhibitor or angiotensin receptor blocker or b) a mineralcorticoid receptor antagonist.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CORTROPHIN (CORTICOTROPIN)

Products Affected

- Cortrophin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use of corticotropin intravenously. Corticotropin should not be used in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpex simplex, recent surgery, history of or active peptic ulcer disease, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin. Corticotropin is contraindicated in patients under the age of 2 with suspected congenital infections and for patients who also have adrenocortical insufficiency or adrenocortical hyperfunction.
Required Medical Information	Medical record documentation of one of the following conditions: 1) Infantile spasms, 2) Acute exacerbation of multiple sclerosis, 3) Exacerbation of rheumatic disorders including psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, or acute gouty arthritis, 4) Exacerbation of or maintenance for collagen diseases including systemic lupus erythematosus, systemic dermatomyositis, 5) Dermatologic diseases including severe erythema multiforme, Stevens-Johnson Syndrome, or severe psoriasis 6) Allergic states such as serum sickness or atopic dermatitis, 7) Ophthalmic diseases including keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, 7) Respiratory diseases such as symptomatic sarcoidosis or 8) Edematous condition from nephrotic syndrome or lupus erythematosus.
Age Restrictions	For infantile spasms: age less than 2 years.
Prescriber Restrictions	N/A
Coverage Duration	Infantile spasms: until two years of age. All others: 1 month.
Other Criteria	For steroid responsive conditions, conditions number 2 to 7 listed in the Required Medical Information section: medical record documentation of failure of corticosteroid therapy in the last 30 days or reason why corticosteroids cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COSENTYX (SECUKINUMAB)

Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

COTELLIC (COBIMETINIB)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRENESSITY (CRINECERFONT)

Products Affected

- Crenessity CAPS 100MG, 50MG
- Crenessity SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Medical record and lab result confirmation of a diagnosis of classic congenital adrenal hyperplasia caused by 21-hydroxylase deficiency. 2) Documentation that Crenessity will be used in combination with supraphysiologic glucocorticoid replacement. Renewal: Documentation of a reduction in daily glucocorticoid replacement dose.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For oral solution only: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRESEMBA (ISAVUCONAZONIUM)

Products Affected

- Cresemba CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	3 months
Other Criteria	For the treatment of invasive aspergillosis (not required for invasive mucormycosis): failure of voriconazole.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRISABOROLE

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: documentation of mild to moderate atopic dermatitis. Renewal: documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist or dermatologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For the treatment of atopic dermatitis if two years and older, initial: failure of 1) tacrolimus ointment or pimecrolimus ointment (requires prior authorization) and 2) if older than 12 years of age: a high potency steroid such as clobetasol.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CTEXLI (CHENODIOL)

Products Affected

- Ctexli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: medical record documentation of a diagnosis of cerebrotendinous xanthomatosis (CTX) confirmed via either a) serum cholestanol and/or urine bile alcohol levels or b) genetic testing. Renewal: medical record documentation of improvements in the symptoms of CTX (such as reduction in diarrhea, decrease in spasticity or hyperreflexia, improvement in ataxia or dysarthria) or reduction in serum cholestanol levels or bile alcohol levels.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an endocrinologist, geneticist, metabolic specialist, or neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CUVRIOR (TRIENTINE TETRAHYDROCHLORIDE)

Products Affected

- Cuvrior

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Medical record documentation of stable Wilson's disease who are de-coppered and tolerant to penicillamine. 2) Renewal: medical record documentation of clinical benefit from treatment with Cuvrior.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: Failure of or contraindication to penicillamine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CYSTEAMINE

Products Affected

- Cystadrops
- Cystaran

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: Medical record documentation of corneal cysteine crystal deposits. Renewal criteria: medical record documentation of a reduction in corneal crystal deposits.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, metabolic disorder specialist, or ophthalmologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DASATINIB

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAURISMO (GLASDEGIB)

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAWNZERA (DONIDALORSEN)

Products Affected

- Dawnzera

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DAYBUE (TROFINETIDE)

Products Affected

- Daybue
- Daybue Stix

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DEFERASIROX

Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions Initial: documentation of elevated sodium ferritin levels. For non-transfusion-dependent thalassemia syndromes Initial: 1) liver iron concentrations at least 5 milligrams of iron per gram of liver dry weight and 2) serum ferritin greater than 300 mcg/L. Renewal criteria for all indications: reduction in total body iron, evidenced by decreased ferritin levels.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	12 months
Other Criteria	For chronic iron overload due to blood transfusions, Initial: Failure of deferoxamine or reason why deferoxamine cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DEFERIPRONE

Products Affected

- Deferiprone
- Ferriprox SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions Initial: documentation of elevated sodium ferritin levels. For transfusional iron overload in patients with sickle cell disease or other anemias, initial: documentation of elevated sodium ferritin levels. Renewal criteria for all indications: reduction in total body iron, evidenced by decreased ferritin levels.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	12 months
Other Criteria	For chronic iron overload due to blood transfusions, Initial: Failure of deferoxamine or reason why deferoxamine cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DEFLAZACORT

Products Affected

- Deflazacort
- Jaythari
- Kymbee
- Pyquvi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DENOSUMAB BIOSIMILARS

Products Affected

- Osenvelt
- Wyost

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Preexisting hypocalcemia. 2) Pregnancy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1) For bone metastasis associated with solid tumors and prevention of skeletal related events in patients with multiple myeloma: documentation of failure of zoledronic acid or there is a contraindication to zoledronic acid that is not a contraindication to denosumab. 2) For the treatment of hypercalcemia of malignancy: failure of one IV bisphosphonate including zoledronic acid or pamidronate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DEXTROMETHORPHAN/QUINIDINE

Products Affected

- Dextromethorphan Hydrobromide/quinidine Sulfate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Complete atrioventricular block without implanted pacemaker or is at high risk for complete AV block.2) Concomitant use with drugs containing quinidine, quinine, mefloquine, drugs that prolong the QT interval and are metabolized by CYP2D6 (thioridazine and pimozide), monoamine oxidase inhibitors. 3) Heart failure. 4) Prolonged QT interval, congenital long QT syndrome or history suggesting torsades de pointes.
Required Medical Information	Initial criteria: Medical record documentation of a diagnosis of pseudobulbar affect. Renewal criteria: documentation of clinical benefit such as improvement in the Center for Neurologic Study Lability Scale or reduction in the number of laughing and crying episodes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DIACOMIT (STIRIPENTOL)

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Medical record documentation of Dravet syndrome. 2) Documentation that Diacomit will be taken with clobazam.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: failure of or contraindication to Epidiolex (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DICHLORPHENAMIDE

Products Affected

- Dichlorphenamide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Documentation of hyperkalemic or hypokalemic periodic paralysis, or related variants of periodic paralysis. Renewal criteria: medical record documentation of a reduction in the number, frequency or duration of paralytic attacks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DIFICID (FIDAXOMICIN)

Products Affected

- Dificid SUSR
- Fidaxomicin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of an infection caused by clostridium difficile.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	10 days
Other Criteria	For oral powder for suspension only: documentation of an inability to swallow oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DOJOLVI (TRIHEPTANOIN)

Products Affected

- Dojolvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD). Renewal: Documentation of improved muscle function, exercise tolerance, or health related quality of life.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DOPTELET (AVATROMBOPAG)

Products Affected

- Doptelet
- Doptelet Sprinkle

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DRIZALMA (DULOXETINE SPRINKLE)

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DRONABINOL

Products Affected

- Dronabinol CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to the treatment of nausea and vomiting associated with cancer chemotherapy: 1) failure of at least one of the following antiemetics: dimenhydrinate, meclizine, metoclopramide, promethazine, or prochlorperazine and 2) ondansetron.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DROXIDOPA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: medical record documentation of treatment response including decrease in lightheadedness, dizziness or falls.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DUPIXENT (DUPILUMAB)

Products Affected

- Dupixent INJ 200MG/1.14ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DUVYZAT (GIVINOSTAT)

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EBGLYSS (LEBRIKIZUMAB-LBKZ)

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EGRIFTA (TESAMORELIN)

Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EKTERLY (SEBETRALSTAT)

Products Affected

- Ekterly

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ELIGARD/LUPRON (LEUPROLIDE)

Products Affected

- Eligard
- Leuprolide Acetate INJ 1MG/0.2ML
- Lupron Depot (1-month) INJ 7.5MG
- Lupron Depot (3-month) INJ 22.5MG
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation supporting the diagnosis submitted.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist, or urologist
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELIQUIS (APIXABAN)

Products Affected

- Eliquis CPSP
- Eliquis TBSO

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Medical record documentation of an inability to swallow solid oral dosage forms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELMIRON (PENTOSAN POLYSULFATE SODIUM)

Products Affected

- Elmiron

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hemorrhagic cystitis
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: medical record documentation of an improvement in symptoms such as a reduction in bladder pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELTROMBOPAG

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EMEND (APREPITANT)

Products Affected

- Aprepitant
- Emend SUSR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concomitant use of pimozide.
Required Medical Information	1) Prophylaxis of post operative nausea and vomiting (PONV): confirmation of diagnosis and use as prophylaxis and not for established nausea and vomiting. 2) Prophylaxis of chemotherapy-induced nausea and vomiting: documentation that aprepitant will be prescribed with concurrent IV or oral ondansetron or granisetron or palonosetron and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PONV: one month. Prophylaxis of chemotherapy-induced nausea and vomiting: 12 months.
Other Criteria	Part B versus D determination will be made to determine coverage.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMGALITY (GALCANEZUMAB-GNLM)

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EMPAVELI (PEGCETACOPLAN)

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EMSAM (SELEGILINE)

Products Affected

- Emsam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Concomitant use of the any of the following medications: SSRIs, SNRIs, TCAs, MAOIs, sympathomimetic amines including amphetamines, meperidine, tramadol, methadone, mirtazapine, bupropion, cyclobenzaprine, carbamazepine and oxcarbamazepine.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of or intolerance to at least 2 of the following: 1) a selective serotonin receptor reuptake inhibitor such as citalopram, escitalopram, fluoxetine, paroxetine, or sertraline, 2) an SNRI such as venlafaxine or duloxetine, 3) bupropion or 4) mirtazapine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENBREL (ETANERCEPT)

Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENDARAVONE

Products Affected

- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a specialist in Amyotrophic Lateral Sclerosis (ALS).
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENDARI (GLUTAMINE)

Products Affected

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: medical record documentation that the drug has been effective in reducing the number of sickle cell crisis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Medical record documentation of failure of or intolerance to hydroxyurea. Failure defined as continued acute complications or pain crisis or continued need for blood transfusions while on hydroxyurea.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENSACOVE (ENSARTINIB)

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENSPRYNG (SATRALIZUMAB-MWGE)

Products Affected

- Enspryng

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of anti-aquaporin-4 (AQP4) antibody positive neuromyelitis optica spectrum disorder
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or ophthalmologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENTYVIO (VEDOLIZUMAB)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EOHILIA (BUDESONIDE)

Products Affected

- Eohilia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: medical record documentation of a diagnosis of eosinophilic esophagitis confirmed by symptoms related to esophageal dysfunction and biopsy showing eosinophil-predominant inflammation (such as a peak value of f ≥15 eosinophils per high power field (HPF) or 60 eosinophils per mm2. Renewal: documentation of a clinical response, such as improvement in dysphagia or histologic remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPIDIOLEX (CANNABIDIOL)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EPOETIN ALFA

Products Affected

- Procrit
- Retacrit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERIVEDGE (VISMODEGIB)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERLEADA (APALUTAMIDE)

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERLOTINIB

Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ESLICARBAZEPINE

Products Affected

- Eslicarbazepine Acetate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of 1) oxcarbazepine and 2) One of the following: carbamazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, lacosamide, levetiracetam.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVENITY (ROMOSOZUMAB-AQQG)

Products Affected

- Evenity

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EVEROLIMUS

Products Affected

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Everolimus TBSO
- Yulithira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, neurologist, transplant specialist or nephrologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EVRYSDI (RISDIPLAM)

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record confirmation of a diagnosis of spinal muscle atrophy (SMA) confirmed by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EXXUA (GEPIRONE)

Products Affected

- Exxua
- Exxua Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Prolonged QTc interval greater than 450msec at baseline. 2) Congenital long QT syndrome. 3) Concomitant use of strong CYP3A4 inhibitors. 4) Severe hepatic impairment. 5) Use with an MAOI or within 14 days of stopping treatment with EXXUA.
Required Medical Information	Medical record documentation of a diagnosis of major depressive disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to new starts only. Initial: failure of two of the following: fluoxetine, sertraline, citalopram, escitalopram, paroxetine, venlafaxine, desvenlafaxine
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FABHALTA (IPTACOPAN)

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FASENRA (BENRALIZUMAB)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FETZIMA (LEVOMILNACIPRAN)

Products Affected

- Fetzima
- Fetzima Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of 1) an SSRI such as sertraline or fluoxetine and 2) an SNRI such as venlafaxine and or duloxetine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FILGRASTIM

Products Affected

- Granix INJ 300MCG/0.5ML, 300MCG/ML, 480MCG/0.8ML
- Zarxio

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FILSPARI (SPARSENTAN)

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FILSUVEZ (BIRCH TRITERPENES)

Products Affected

- Filsuvez

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FINGOLIMOD

Products Affected

- Fingolimod Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Unstable angina, transient ischemic attack, myocardial infarction, stroke, heart failure Class III/IV or decompensated heart failure requiring hospitalization within the last 6 months. 2) Concomitant Class Ia or Class III anti-arrhythmic drugs. 3) Mobitz type II second-degree, third-degree atrioventricular block, sick-sinus syndrome unless the patient has a functional pacemaker. 4) QTc interval at baseline 500 milliseconds or greater.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
Other Criteria	Documentation that fingolimod is being requested for monotherapy and is not intended to be used in combination with other disease modifying multiple sclerosis agents.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FINTEPLA (FENFLURAMINE)

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of or contraindication to Epidiolex (requires PA for new starts).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FIRDAPSE (AMIFAMPRIDINE)

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FIRMAGON (DEGARELIX)

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FOTIVDA (TIVOZANIB)

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FRUZAQLA (FRUQUINTINIB)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GALAFOLD (MIGALASTAT)

Products Affected

- Galafold

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GARDASIL (HPV VACCINE)

Products Affected

- Gardasil 9 INJ 0.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Between 9 years and 45 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GATTEX (TEDUGLUTIDE)

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

GAVRETO (PRALSETINIB)

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GEFITINIB

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GEMTESA (VIBEGRON)

Products Affected

- Gemtesa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: for overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in adult males on pharmacological therapy for benign prostatic hyperplasia (BPH), documentation that the member is receiving pharmacological therapy for BPH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria does not apply to adult males with BPH: Failure of mirabegron.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GILOTRIF (AFATINIB)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLYCEROL PHENYLBUTYRATE

Products Affected

- Glycerol Phenylbutyrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of urea cycle disorder confirmed by DNA testing. Renewal: Medical record documentation of stabilization of disease progression such as stabilization of neurologic impairments or seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Failure of sodium phenylbutyrate powder (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GOMEKLI (MIRDAMETINIB)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GRANISETRON

Products Affected

- Granisetron Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prevention or treatment of nausea and vomiting associated with cancer chemotherapy or radiation: documentation of current treatment with 1) moderately or highly emetogenic chemotherapy or 2) total body, upper hemi-body or abdominal irradiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Nausea and vomiting, cancer treatment: 12 months. Post-operative nausea and vomiting: one month.
Other Criteria	1) Not receiving concurrent oral or IV ondansetron, Kytril, Anzemet or Emend. 2) If granisetron is being used as part of a cancer chemotherapy regimen, Part B versus D determination will be made to determine coverage.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GRASTEK (TIMOTHY GRASS POLLEN ALLERGEN)

Products Affected

- Grastek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of a positive skin test or pollen specific IgE antibodies to Timothy grass or cross-reactive grass pollens.
Age Restrictions	65 years of age or younger
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	Lifetime
Other Criteria	Failure of or contraindication to 1) an oral or nasal antihistamine such as desloratadine tablets or azelastine nasal spray) and 2) an intranasal corticosteroid such as flunisolide nasal spray.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HAEGARDA (HUMAN C1 ESTERACE INHIBITOR)

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

HERNEXEOS (ZONGERTINIB)

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HETLIOZ (TASIMELTEON)

Products Affected

- Hetlioz Lq
- Tasimelteon

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

HYDROXYZINE

Products Affected

- Hydroxyzine Hcl TABS 50MG
- Hydroxyzine Hydrochloride SYRP 10MG/5ML
- Hydroxyzine Hydrochloride TABS 10MG, 25MG
- Hydroxyzine Pamoate CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYFTOR (SIROLIMUS)

Products Affected

- Hyftor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: medical record documentation of a confirmation of facial angiofibroma associated with tuberous sclerosis. Renewal: medical record documentation of a clinical response to therapy, such as improvement in size or redness of facial angiofibroma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 12 weeks. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYRNUO (SEVABERTINIB)

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBRANCE (PALBOCICLIB)

Products Affected

- Ibrance CAPS 125MG
- Ibrance TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBTROZI (TALETRECTINIB ADIPATE)

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: 1) Failure of, intolerance or contraindication to: a) Xalkori and 2) Rozyltrek. Both require prior authorization. 2) Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ICATIBANT

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Documentation of hereditary angioedema Type 1 and II confirmed by genetic testing or complement studies of C4, C1INH antigenic and C1INH functional levels supporting the diagnosis. For hereditary angioedema Type III, documentation of diagnosis confirmed by genetic testing, normal complement studies combined with clinical features of angioedema or family history. Renewal: documentation of benefit from use of icatibant.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, allergist or immunologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ICLUSIG (PONATINIB)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IDHIFA (ENASIDENIB)

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMATINIB

Products Affected

- Imatinib Mesylate TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMBRUVICA (IBRUTINIB)

Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 140MG, 280MG, 420MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IMKELDI (IMATINIB)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INBRIJA (LEVODOPA)

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INCRELEX (MECASERMIN)

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Evidence of closure of epiphyseal plate. 2) Active or suspected neoplasia.
Required Medical Information	1) Primary IGF-1 Deficiency, Initial: a) Secondary causes have been ruled out, such as growth hormone deficiency, malnutrition, hypothyroidism, and chronic corticosteroid therapy, b) Height standard deviation score less than or equal to -3, c) basal IGF-1 standard deviation score of less than or equal to -3 and d) normal or elevated growth hormone, greater than or equal to 10ng/ml to at least two stimuli including insulin, levodopa, arginine, clonidine, or glucagon. Renewal criteria: documentation of clinical improvement, such as an increase in height velocity. 2) Growth Hormone Gene Deletion Initial: evidence of gene deletion and (+) neutralizing antibodies to growth hormone. Renewal criteria: documentation of clinical improvement, such as an increase in height velocity.
Age Restrictions	Between 2 years and 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INGREZZA (VALBENAZINE)

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INLURIYO (IMLUNESTRANT)

Products Affected

- Inluriyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INLYTA (AXITINIB)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INQOVI (DECITABINE-CEDAZURIDINE)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INREBIC (FEDRATINIB)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	1) Failure of Jakafi or the prescriber must provide a medical reason why Jakafi cannot be used. 2) Drug must be prescribed for an FDA approved indication or a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex if for non-cancer use, or supported by NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, and acceptable medical journals for cancer indication.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INSULIN ADMINISTRATION SUPPLIES

Products Affected

- Alcohol Prep Pads PADS 70%
- Bd Insulin Syringe Safetyglide/1ml/29g X 1/2"
- B-d Insulin Syringe Ultrafine Ii/0.3ml/31g X 5/16"
- Bd Insulin Syringe Ultra-fine/0.5ml/30g X 12.7mm
- Bd Insulin Syringe Ultra-fine/1ml/31g X 8mm
- Bd Pen Needle/original/ultra-fine/29g X 12.7mm
- Curity Gauze Pads 2"x2" 12 Ply

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of or claims history of insulin use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INTRAVENOUS IMMUNE GLOBULIN

Products Affected

- Bivigam INJ 5GM/50ML
- Gammagard Liquid INJ 10GM/100ML, 2.5GM/25ML, 5GM/50ML
- Gammagard Liquid Erc
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 1GM/10ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 5GM/50ML
- Gamunex-c INJ 1GM/10ML
- Octagam INJ 1GM/20ML, 2GM/20ML
- Privigen INJ 20GM/200ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INVEGA (PALIPERIDONE EXTENDED RELEASE INJECTION)

Products Affected

- Invega Hafyera
- Invega Trinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The following criteria applies to members who newly start on the drug. 1) For Invega Hafyera: medical record documentation or evidence from claims history that Invega Sustenna has been used for 4 months OR that Invega Trinza has been used for 3 months. 2) For Invega Trinza: medical record documentation or evidence from claims history that Invega Sustenna has been used for 4 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IQIRVO (ELAFIBRANOR)

Products Affected

- Iqirvo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ISOTRETINOIN

Products Affected

- Accutane CAPS 10MG, 20MG, 40MG
- Amnesteem
- Claravis CAPS 10MG
- Isotretinoin CAPS 10MG, 20MG, 30MG, 40MG
- Zenatane

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Females who are pregnant or who may become pregnant and are not using at least two forms of contraception.
Required Medical Information	Medical record documentation of negative pregnancy test and use of reliable methods of birth control in females of child-bearing age.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist.
Coverage Duration	20 weeks
Other Criteria	Documentation of failure of at least a 4 week trial of a) one oral antibiotic (e.g., tetracycline, doxycycline, minocycline, or erythromycin) and b) topical tretinoin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ISTURISA (OSILODROSTAT)

Products Affected

- Isturisa TABS 1MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: a) confirmation of a diagnosis of endogenous hypercortisolemia in adults with Cushing's syndrome. b) prescriber attestation that surgery is not an option or medical record documentation supporting that surgery has not been curative. Renewal: Lab results showing urinary free cortisol levels less than or equal to the upper limit of normal.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ITOVEBI (INAVOLISIB)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IWILFIN (EFLORNITHINE)

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JAKAFI (RUXOLITINIB)

Products Affected

- Jakafi
- Jakafi Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, or transplant specialist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JAYPIRCA (PIRTOBRUTINIB)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JIDEYTRO (ZIDESAMTINIB)

Products Affected

- Jideytro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JOENJA (LENIOLISIB)

Products Affected

- Joenja TABS 70MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

JOURNAVX (SUZETRIGINE)

Products Affected

- Journavx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of moderate to severe acute pain and that treatment is intended to be 14 days or less.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Failure of, intolerance to, or contraindication to 1) an NSAID, and 2) a short-acting opioid. Short-acting opioids are not required if there is a history or risk of substance use disorder.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JUXTAPID (LOMITAPIDE)

Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: diagnosis of homozygous familial hypercholesterolemia. Renewal criteria: reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Failure of or intolerance to: 1) ezetimibe and 2) rosuvastatin or atorvastatin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KALYDECO (IVACAFTOR)

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: mutation that is responsive to Kalydeco. Renewal: clinical benefit such as a) slowing of disease progression, or b) improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KERENDIA (FINERENONE)

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of 1) a) diagnosis of chronic kidney disease associated with type 2 diabetes and b) eGFR of at least 25 mL/min/1.73m2 or 2) heart failure with left ventricular ejection fraction (LVEF) greater than or equal to 40%.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or a cardiologist.
Coverage Duration	Lifetime
Other Criteria	Heart failure, initial: failure of, intolerance to, or contraindication to a SGLT-2 inhibitor such as Farxiga.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KINERET (ANAKINRA)

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KISQALI (RIBOCICLIB)

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOMZIFTI (ZIFTOMENIB)

Products Affected

- Komzifti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORLYM (MIFEPRISTONE)

Products Affected

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Not covered for use in patients with type 2 diabetes mellitus that is not associated with Cushing's syndrome. 2) Not covered in pregnant females.
Required Medical Information	Initial criteria: Documentation of failure of surgical treatment or the patient is not a candidate for surgery. Renewal criteria: documentation of a reduction in HbA1c or has reached target HbA1c.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOSELUGO (SELUMETINIB)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Medical record documentation of the diagnosis. 2) Medical record documentation of an inability to swallow solid oral dosage forms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, neurologist or geneticist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KRAZATI (ADAGRASIB)

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LACLUZE (LAZERTINIB)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LAMPIT (NIFURTIMOX)

Products Affected

- Lampit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of Chagas disease caused by T. cruzi confirmed by detection of T. cruzi trypomastigotes on microscopy, detection of T. cruzi DNA by PCR assay, or 2 positive diagnostic serologic tests using two different techniques and antigens showing IgG antibodies to T. cruzi.
Age Restrictions	Between 0 years and 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or cardiologist.
Coverage Duration	60 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LANTHANUM

Products Affected

- Fosrenol PACK
- Lanthanum Carbonate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	When the member is receiving dialysis for end stage renal disease, the drug will be covered under Part B and provided by the dialysis center. For those not receiving dialysis: Trial of calcium acetate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LAPATINIB

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LENALIDOMIDE

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LENVIMA (LENVATINIB)

Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEQEMBI IQLIK (LECANEMAB-IRMB)

Products Affected

- Leqembi Iqlik INJ 360MG/1.8ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEUKINE (SARGRAMOSTIM)

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) AIDS Neutropenia and 2) Myelodysplastic Syndromes
Exclusion Criteria	N/A
Required Medical Information	Documentation of one the following: a) receiving myelosuppressive chemotherapy for a non-myeloid malignancy, receiving chemotherapy for AML, post-induction chemotherapy for AML, or acute exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome), or b) BMT (allogeneic or autologous) or c) autologous peripheral blood progenitor cell (PBPC) transplant or d) severe chronic neutropenia and not on interferon-ribavirin based Hepatitis C treatment or e) AIDS, or f) myelodysplastic syndromes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDOCAINE PATCH

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) Diabetic peripheral neuropathy, 2) Cancer neuropathic pain, 3) Chronic back pain, 4) Osteoarthritis of hip or knee.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIFYORLI (RELACORILANT)

Products Affected

- Lifyorli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LISDEXAMFETAMINE

Products Affected

- Lisdexamfetamine Dimesylate CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Attention deficit hyperactivity disorder only: trial of 1) amphetamine-dextroamphetamine ER capsules or dextroamphetamine ER and 2) methylphenidate ER or dexmethylphenidate ER.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LITHIUM SOLUTION

Products Affected

- Lithium

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria only applies to members who newly start on the drug: Medical record documentation of an inability to swallow solid dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIVDELZI (SELADELPAR)

Products Affected

- Livdelzi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LIVMARLI (MARALIXIBAT)

Products Affected

- Livmarli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of pruritis associated with Alagille syndrome OR cholestatic pruritis due to progressive familial intrahepatic cholestasis (PFIC). Renewal: Medical record documentation of clinical benefit, such as a decrease in pruritis, or improvement in quality of life.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIVTENCITY (MARIBAVIR)

Products Affected

- Livtencity

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LODOCO (CV COLCHICINE)

Products Affected

- Lodoco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of established atherosclerotic cardiovascular disease or multiple risk factors for cardiovascular disease.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or lipid specialist.
Coverage Duration	Lifetime
Other Criteria	Failure of or intolerance to two statins, such as atorvastatin or rosuvastatin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LONSURF (TRIFLURIDINE-TIPIRACIL)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LORBRENA (LORLATINIB)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUCEMYRA (LOFEXIDINE)

Products Affected

- Lofexidine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUMAKRAS (SOTORASIB)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPKYNIS (VOCLOSPORIN)

Products Affected

- Lupkynis

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LUPRON (LEUPROLIDE ACETATE)

Products Affected

- Lupron Depot (1-month) INJ 3.75MG
- Lupron Depot (3-month) INJ 11.25MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LYBALVI (OLANZAPINE-SAMIDORPHAN)

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients using opioids or undergoing acute opioid withdrawal.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of two of the following: risperidone, aripiprazole, quetiapine IR and ER, ziprasidone, or asenapine (requires step therapy for new starts).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYNPARZA (OLAPARIB)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYTGOBI (FUTIBATINIB)

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MACITENTAN

Products Affected

- Macitentan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy
Required Medical Information	Documentation of World Health Organization (WHO) functional class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Lifetime
Other Criteria	Failure of or contraindication to 1) sildenafil or tadalafil and 2) bosentan or ambrisentan. All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAYZENT (SIPONIMOD)

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
Other Criteria	Documentation that Mayzent is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEBENDAZOLE

Products Affected

- Emverm

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record confirmation of an infection caused by Ancylostoma duodenale (common hookworm), Necator americanus (American hookworm), Enterobius vermicularis (pinworm), Trichuris , (whipworm), or Ascaris lumbricoides (common roundworm).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKINIST (TRAMETINIB)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKTOVI (BINIMETINIB)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MERCAPTOPURINE SUSPENSION

Products Affected

- Mercaptopurine SUSP

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

METHITEST (METHYLTESTOSTERONE)

Products Affected

- Methitest

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Men with carcinoma of the breast. 2) Men with known or suspected carcinoma of the prostate.
Required Medical Information	1) For members newly started on the drug for the treatment of primary or secondary hypogonadism: a) total testosterone level less than 300 ng/dL or b) free testosterone level below the normal range for age and gender. 2) Delayed puberty: Skeletal age of at least 12 or chronological age of at least 14.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist for metastatic breast cancer.
Coverage Duration	Delayed puberty: 6 months. All other diagnoses: Lifetime.
Other Criteria	For treatment of secondary hypogonadism: failure of testosterone cypionate and topical testosterone gel.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

METHOTREXATE SOLUTION

Products Affected

- Jylamvo
- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid dosage forms. 2) For the treatment of cancer, Part B versus D determination will be made to determine coverage.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

METYROSINE

Products Affected

- Metyrosine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of scheduled surgical resection or if no surgical intervention planned, documentation of contraindication to surgery or malignant pheochromocytoma.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, oncologist or nephrologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MILNACIPRAN

Products Affected

- Milnacipran Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of fibromyalgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of two of the following: pregabalin, duloxetine, or amitriptyline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MIPLYFFA (ARIMOCLOMOL)

Products Affected

- Miplyffa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: a) confirmation of a diagnosis of Niemann-Pick disease type C (NPC) by genetic testing, b) documentation of neurologic symptoms due to NPC, and c) documentation that Miplyffa will be prescribed in combination with miglustat.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist or neurologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MODAFINIL

Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MODEYSO (DORDAVIPRONE)

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MOUNJARO (TIRZEPATIDE)

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of type 2 diabetes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MOVANTIK (NALOXEGOL OXALATE)

Products Affected

- Movantik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Opioid-induced constipation in adults with chronic non-cancer pain: documentation of fewer than 3 spontaneous bowel movements per week.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MULPLETA (LUSUTROMBOPAG)

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Platelets less than 50k.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hematologist, hepatologist or surgeon.
Coverage Duration	7 days
Other Criteria	Documentation of upcoming procedure.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MULTAQ (DRONEDARONE)

Products Affected

- Multaq

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MYALEPT (METRELEPTIN)

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MYCAPSSA (OCTREOTIDE)

Products Affected

- Mycapssa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation showing: 1) a diagnosis of acromegaly, 2) response and tolerance to treatment with octreotide or lanreotide, and 3) that it is not appropriate to continue treatment with injection or depot. Renewal: documentation of IGF-1 normalization or symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MYFEMBREE (RELUGOLIX-ESTRADIOL-NORETHINDRONE)

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MYQORZO (AFICAMTEN)

Products Affected

- Myqorzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) medical record documentation of NYHA class II or III obstructive hypertrophic cardiomyopathy and 2) documentation of left ventricular ejection fraction of greater than or equal to 55%. Renewal: 1) documentation of left ventricular ejection fraction of greater than 40% and 2) improvement in symptoms or functioning.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NERLYNX (NERATINIB)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If not prescribed for a FDA approved indication, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information, NCCN (National Comprehensive Cancer Network) guidelines, Micromedex DrugDex or peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXLETOL (BEMPEDOIC ACID)

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NEXLIZET (BEMPEDOIC ACID AND EZETIMIBE)

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NILOTINIB

Products Affected

- Danziten
- Nilotinib Hydrochloride

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NINLARO (IXAZOMIB)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NITAZOXANIDE

Products Affected

- Nitazoxanide TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cryptosporidiosis in HIV infected patients
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of cryptosporidiosis in HIV infected patients: documentation that the patient is on antiretroviral therapy (ART) or if the patient is not on ART then ART is being initiated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Cryptosporidiosis and Giardiasis: 3 days. Cryptosporidiosis, HIV: 14 days.
Other Criteria	For suspension: documentation that the tablet is not indicated for the member's age, or of an inability to take solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NITISINONE

Products Affected

- Nitisinone
- Orfadin SUSP

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NITYR (NITISINONE)

Products Affected

- Nityr

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUBEQA (DAROLUTAMIDE)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUCALA (MEPOLIZUMAB)

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUPLAZID (PIMAVANSERIN)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NURTEC (RIMEGEPANT)

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ODACTRA (DUST MITE ALLERGEN)

Products Affected

- Odactra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of a positive skin test to licensed house dust mite allergen extracts or positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites.
Age Restrictions	65 years of age or younger
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	Lifetime
Other Criteria	Failure of or contraindication to 1) an oral or nasal antihistamine such as desloratadine tablets or azelastine nasal spray) and 2) an intranasal corticosteroid such as flunisolide nasal spray.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ODOMZO (SONIDEGIB)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OFEV (NINTEDANIB)

Products Affected

- Nintedanib Esylate
- Ofev

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OGSIVEO (NIROGACESTAT)

Products Affected

- Ogsiveo TABS 100MG, 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA (TOVORAFENIB)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJJAARA (MOMELOTINIB)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONUREG (AZACITIDINE)

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPIPZA (ARIPIPRAZOLE FILM)

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORAL RIBAVIRIN

Products Affected

- Ribavirin CAPS
- Ribavirin TABS 200MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORENCIA (ABATACEPT)

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML
- Orencia Clickject

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORENITRAM (TREPROSTINIL)

Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORGOVYX (RELUGOLIX)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of an FDA approved or medically accepted indication.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with oncologist or urologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORIAHNN (ELAGOLIX-ESTRADIOL-NORETHINDRONE)

Products Affected

- Oriahnn

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ob/gyn specialist.
Coverage Duration	24 months
Other Criteria	Failure of or contraindication to: 1) oral contraceptives and 2) tranexamic acid.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORILISSA (ELAGOLIX)

Products Affected

- Orilissa

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORKAMBI (LUMACAFTOR-IVACAFTOR)

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORSERDU (ELACESTRANT)

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OTEZLA (APREMILAST)

Products Affected

- Otezla
- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OXERVATE (CENEGERMIN-BKBJ)

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OXYBUTYNIN

Products Affected

- Oxybutynin Chloride SOLN
- Oxybutynin Chloride TABS 5MG
- Oxybutynin Chloride Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: Initial: 1) medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq), and 2) prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects. Renewal: prescriber attestation that the benefits of therapy continue to outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OXYCODONE EXTENDED RELEASE

Products Affected

- Oxycontin T12A

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of sustained release morphine sulfate and not receiving concurrent therapy with another long-acting opioid, such as fentanyl or sustained release morphine sulfate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OZEMPIC (SEMAGLUTIDE)

Products Affected

- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML
- Ozempic TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of type 2 diabetes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PALYNZIQ (PEGVALIASE-PQPZ)

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Phenylalanine level (Phe) at or above 600 micromol/L. Renewal: Reduction in Phe levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PANRETIN (ALITRETINOIN)

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of cutaneous lesions associated with AIDS-related Kaposi's sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PARICALCITOL

Products Affected

- Paricalcitol CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Hypercalcemia and vitamin D toxicity.
Required Medical Information	1) Stage 3 Chronic Kidney Disease (CKD): a) GFR 30-59, b) serum calcium less than 9.5 mg/dL, c) serum phosphorus less than or equal to 4.6 mg/dL. 2) Stage 4 CKD: a) GFR 15-29, b) serum calcium less than 9.5 mg/dL, c) serum phosphorus less than or equal to 4.6 mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) Failure of or intolerance to calcitriol or reason why calcitriol cannot be used. 2) For end stage renal disease (ESRD) patients, Part B versus Part D determination will be made to determine if the drug prescribed will be used for an ESRD-related condition. For ESRD-related conditions, the drug will be covered under Part B and provided by the dialysis center.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PAROXETINE SUSPENSION

Products Affected

- Paroxetine Hydrochloride SUSP

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PAZOPANIB

Products Affected

- Pazopanib Hydrochloride TABS 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PEGASYS (PEGINTERFERON ALFA-2A)

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PEGFILGRASTIM

Products Affected

- Fulphila
- Neulasta INJ 6MG/0.6ML
- Stimufend
- Udenyca

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PEMAZYRE (PEMIGATINIB)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PENBRAYA (MENINGOCOCCAL VACCINE)

Products Affected

- Penbraya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Between 10 years and 25 years of age
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PENMENVY (MENINGOCOCCAL VACCINE)

Products Affected

- Penmenvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prior authorization does not apply to members between 10 years and 25 years of age.
Age Restrictions	Between 10 years and 25 years of age
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PENTAMIDINE

Products Affected

- Pentamidine Isethionate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, oncologist, or hematologist.
Coverage Duration	21 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PERAMPANEL

Products Affected

- Perampanel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: 1) For the treatment of partial-onset seizures: failure of two of the following: carbamazepine, oxcarbazepine, lacosamide, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, and levetiracetam. 2) For the treatment of primary generalized tonic-clonic seizures: failure of two of the following topiramate, lacosamide, lamotrigine, phenytoin, and levetiracetam. 3) For solution only: For all indications, inability to swallow oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIMECROLIMUS

Products Affected

- Pimecrolimus

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Primary cutaneous lymphomas
Exclusion Criteria	N/A
Required Medical Information	For treatment of primary cutaneous lymphomas: documentation of mycosis fungoides.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or oncologist.
Coverage Duration	Lifetime
Other Criteria	For treatment of atopic dermatitis, initial: failure of 1) tacrolimus ointment and 2) if older than 12 years of age: a high potency steroid such as clobetasol.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIQRAY (ALPELISIB)

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PIRFENIDONE

Products Affected

- Pirfenidone

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

POMALIDOMIDE

Products Affected

- Pomalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist or HIV specialist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POSACONAZOLE

Products Affected

- Noxafil PACK
- Posaconazole SUSP
- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Candidiasis: 1 month. Aspergillosis: 3 months. Prophylaxis of invasive fungal infections: 6 months.
Other Criteria	For all dosage forms oropharyngeal candidiasis or prophylaxis of invasive fungal infections in a patient who has received a hematopoietic stem-cell transplant or has chemotherapy-induced neutropenia due to hematologic malignancy: failure of fluconazole tablet or suspension or itraconazole capsule or solution. For suspension only: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PRALUENT (ALIROCUMAB)

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PRENATAL VITAMINS

Products Affected

- Prenatal TABS 120MG; 0; 200MG; 10MCG; 2MG; 12MCG; 27MG; 1MG; 20MG; 10MG; 1200MCG; 3MG; 1.84MG; 10MG; 25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Male gender
Required Medical Information	N/A
Age Restrictions	Prior authorization is only required for patients 51 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PRETOMANID

Products Affected

- Pretomanid

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PREVYMIS (LETERMOVIR)

Products Affected

- Prevymis TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of 1) the patient is receiving or will receive an allogenic hematopoietic stem cell transplant and is at risk for cytomegalovirus (CMV) infection because of the patient's CMV-seropositive status or the donor's status. OR 2) that the patient is receiving or will receive a kidney transplant and is at high risk of CMV infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	200 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PROMETHAZINE

Products Affected

- Promethazine Hcl SUPP 12.5MG
- Promethazine Hydrochloride ORAL SOLN 6.25MG/5ML
- Promethazine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PRUCALOPRIDE

Products Affected

- Prucalopride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of fewer than 3 spontaneous bowel movements per week.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PYRUKYND (MITAPIVAT)

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: medical record documentation of a diagnosis of hemolytic anemia with pyruvate kinase deficiency confirmed by genetic testing. Renewal: documentation of a reduction in transfusion requirements from baseline.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist, or genetic specialist
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QBREXZA (GLYCOPYRRONIUM)

Products Affected

- Qbrexza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: medical record documentation of an improvement in symptoms.
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QINLOCK (RIPRETINIB)

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QUININE SULFATE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RALDESY (TRAZODONE SOLUTION)

Products Affected

- Raldesy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concomitant use of monoamine oxidase inhibitors (MAOIs), or use within 14 days of stopping MAOIs.
Required Medical Information	1) Medical record documentation of a diagnosis of major depressive disorder.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documented inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REDEMPLO (PLOZASIRAN)

Products Affected

- Redemplo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RELISTOR (METHYLNALTREXONE)

Products Affected

- Relistor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	1) For the treatment of opioid-induced constipation in patients with advanced illness receiving palliative care: a) Receiving palliative care for advanced illness and b) Receiving chronic opioid therapy. 2) For the treatment of opioid-induced constipation in patients with chronic noncancer pain: a) documentation of less than 3 spontaneous bowel movements per week b) Receiving chronic opioid therapy for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	For the treatment of opioid-induced constipation in patients receiving palliative care and using injections, dosing consistent with product label: a) 38 kg to less than 62 kg, 8 mg/dose. b) 62 kg to 114 kg, 12 mg/dose. c) Less than 38 kg or greater than 114 kg, 0.15/kg/dose.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REPATHA (EVOLOCUMAB)

Products Affected

- Repatha
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RETEVMO (SELPERCATINIB)

Products Affected

- Retevmo TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVCOVI (ELAPEGADEMASE)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: laboratory result confirmation of a diagnosis of adenosine deaminase severe combined immune deficiency (ADASCID). Renewal: medical record documentation of a clinical response to Revcovi, and that monitoring recommended per the FDA labeling is being completed.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an immunologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVUFORJ (REVUMENIB)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZDIFFRA (RESMETIROM)

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: a) Medical record documentation of noncirrhotic nonalcoholic steatohepatitis (NASH). 2) Documentation of moderate to advanced liver fibrosis, Stage F2 or F3.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZLIDHIA (OLUTASIDENIB)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZUROCK (BELUMOSUDIL)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Medical record documentation of a diagnosis of chronic graft vs host disease.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, or transplant specialist.
Coverage Duration	Lifetime
Other Criteria	For patients age 18 and older: Failure of or contraindication to 1) Jakafi and 2) Imbruvica. Both require prior authorization. For patients age 12 to 17: Failure of or contraindication to Jakafi.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ (UPDACITINIB)

Products Affected

- Rinvoq
- Rinvoq Lq

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RIOCIGUAT

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: 1) For patients with WHO Group 4 pulmonary arterial hypertension - chronic thromboembolic pulmonary arterial hypertension: failure of surgical treatment or would not be a candidate for surgical treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Lifetime
Other Criteria	Initial criteria for patients with WHO Group 1 pulmonary arterial hypertension: Medical record documentation of failure of or would be a poor candidate for the following: 1) A phosphodiesterase type 5 (PDE-5) inhibitor such as sildenafil or tadalafil and 2) An endothelin receptor antagonist such as ambrisentan or bosentan.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RISEDRONATE

Products Affected

- Risedronate Sodium

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Osteoporosis: failure of alendronate and ibandronate. Paget's disease: failure of alendronate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RIVAROXABAN SUSPENSION

Products Affected

- Rivaroxaban SUSR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Documentation of an inability to swallow oral tablets.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RIVFLOZA (NEDOSIRAN)

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Confirmation of primary hyperoxaluria type 1 (PH1) with elevated urinary oxalate excretion and genetic testing. Renewal: medical record documentation of reduction in urinary oxalate excretion.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROMVIMZA (VIMSELTINIB)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROZLYTREK (ENTRECTINIB)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to new starts only. Initial: Documentation of an inability to swallow solid oral dosage forms. Drug must be prescribed for a FDA approved indication or a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex for non-cancer indications, and supported by NCCN Compendium, Clinical Pharmacology, Lexi-Drugs, and acceptable medical journals for cancer indications.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUBRACA (RUCAPARIB)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUFINAMIDE SUSPENSION

Products Affected

- Rufinamide SUSP 40MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documentation of an inability to take solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYDAPT (MIDOSTAURIN)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RYTARY (CARBIDOPA LEVODOPA ER CAP)

Products Affected

- Rytary

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SAPROPTERIN

Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: Documentation of response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SCEMBLIX (ASCIMINIB)

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SCOPOLAMINE PATCH

Products Affected

- Scopolamine PT72 1MG/3DAYS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Excessive salivation prophylaxis
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Post-op nausea and vomiting and motion sickness: 1 month. Excessive salivation: 12 months.
Other Criteria	For the treatment of motion sickness: failure of or intolerance to meclizine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SECUADO (ASENAPINE PATCH)

Products Affected

- Secuado

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Documentation of trial of, intolerance to, or contraindication to asenapine sublingual tablets (requires step therapy for new starts).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SEPHIENCE (SEPIAPTERIN)

Products Affected

- Sephience

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: medical record documentation supporting a diagnosis of hyperphenylalaninemia with sepiapterin-responsive phenylketonuria (PKU). Renewal: Documentation of a clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or metabolic specialist.
Coverage Duration	Initial: 3 months. Renewal: Lifetime
Other Criteria	Initial: failure of sapropterin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIGNIFOR (PASIREOTIDE)

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: decrease in urinary free cortisol or improvement in signs or symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIKLOS (HYDROXYUREA)

Products Affected

- Siklos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of sickle cell anemia with crisis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SILDENAFIL (PULMONARY ARTERIAL HYPERTENSION)

Products Affected

- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SIMPONI (GOLIMUMAB)

Products Affected

- Simponi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SIRTURO (BEDAQUILINE)

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SKYCLARYS (OMAVELOXOLONE)

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of Friedreich's ataxia (FA or FRDA) confirmed by genetic testing. Renewal: medical record documentation of a slowing of progression or clinical benefit.
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYRIZI (RISANKIZUMAB-RZAA)

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SODIUM OXYBATE ORAL SOLUTION

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SODIUM PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOFDRA (SOFPIRONIUM)

Products Affected

- Sofdra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal criteria: medical record documentation of an improvement in symptoms.
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: failure of Qbrexza (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOHONOS (PALOVAROTENE)

Products Affected

- Sohonos CAPS 1.5MG, 10MG, 1MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Medical record documentation of a diagnosis of fibrodysplasia ossificans progressiva (FOP), confirmed by ACVR1 R206H mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOLIFENACIN

Products Affected

- Solifenacin Succinate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: Initial: medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq), and prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects. Renewal: prescriber attestation that the benefits of therapy continue to outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOLTAMOX (TAMOXIFEN ORAL SOLUTION)

Products Affected

- Soltamox

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOMATROPIN

Products Affected

- Genotropin
- Genotropin Miniquick
- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro INJ 10MG/1.5ML, 15MG/1.5ML, 5MG/1.5ML
- Omnitrope

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOMAVERT (PEGVISOMANT)

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SORAFENIB

Products Affected

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOTYLIZE (SOTALOL ORAL SOLUTION)

Products Affected

- Sotylize

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Medical record documentation of an inability to take solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRITAM (LEVETIRACETAM)

Products Affected

- Levetiracetam TB3D

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Evidence from documentation or claims history that Spritam is not being used as monotherapy for myoclonic seizures or primary generalized tonic-clonic seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: For all diagnoses: rationale why oral tablets or oral solution is not appropriate. 1) For the treatment of partial-onset seizures, failure of one of the following: carbamazepine tablet/chew tablet/suspension, oxcarbazepine tablet/suspension, phenytoin capsule/chew tablet/suspension, topiramate, divalproex, felbamate tablet/suspension, tiagabine, lamotrigine tablet/chew tablet/oral disintegrating tablet, gabapentin tablet/capsule/solution, lacosamide tablet/suspension or zonisamide. 2) For the treatment of primary generalized tonic-clonic seizures, failure of one of the following: topiramate, lamotrigine tablet/chew tablet/oral disintegrating tablet, phenytoin capsule/chew tablet/suspension, lacosamide tablet/suspension or carbamazepine tablet/chew tablet/suspension. 3) For the treatment of myoclonic seizures, failure of one of the following: divalproex, lamotrigine tablet/chew tablet/oral disintegrating tablet or topiramate.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

STIVARGA (REGORAFENIB)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUCRAID (SACROSIDASE)

Products Affected

- Sucraid

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SUNITINIB

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYMDEKO (TEZACAFTOR-IVACAFTOR)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: Medical record documentation of a diagnosis of cystic fibrosis homozygous for the F508del mutation or has a mutation that is responsive to the drug confirmed using an FDA-cleared cystic fibrosis mutation test. Renewal criteria: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYMPAZAN (CLOBAZAM FILM)

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Sympazan must be used as adjunctive treatment.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: 1) For Lennox-Gastaut, petit mal variant, failure of a) clonazepam and b) one of the following: valproate, topiramate, lamotrigine, felbamate or rufinamide. 2) For Lennox-Gastaut, other seizure types, failure of two of the following: clonazepam, valproate, topiramate, lamotrigine, felbamate or rufinamide. 3) For all indications, documentation of an inability to swallow solid and liquid dosage forms (tablets and suspension).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYMPROIC (NALDEMEDINE)

Products Affected

- Symproic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of fewer than 3 spontaneous bowel movements per week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYNAREL (NAFARELIN)

Products Affected

- Synarel

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TABRECTA (CAPMATINIB)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TADALAFIL (BENIGN PROSTATIC HYPERPLASIA)

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of a diagnosis of benign prostatic hyperplasia (BPH). Renewal: medical record documentation of an improvement in symptoms of BPH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Initial: failure of 1) an alpha blocker such as tamsulosin or alfuzosin and 2) an alpha reductase inhibitor such as finasteride or dutasteride.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TADALAFIL (PULMONARY ARTERIAL HYPERTENSION)

Products Affected

- Alyq
- Tadalafil TABS 20MG
- Tadliq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use of nitrates.
Required Medical Information	Documentation of New York Heart Association (NYHA) Class II or III.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Lifetime
Other Criteria	For Tadliq: documentation of an inability to swallow oral tablets or capsules.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFINLAR (DABRAFENIB)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAGRISSO (OSIMERTINIB)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAKHZYRO (LANADELUMAB-FLYO)

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TALZENNA (TALAZOPARIB)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TARPEYO (BUDESONIDE)

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TAVALISSE (FOSTAMATINIB)

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TAVNEOS (AVACOPAN)

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazarotene GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) For acne vulgaris: documentation of failure of topical tretinoin. 2) For psoriasis vulgaris: documentation of failure of a mid-to-high potency topical corticosteroid (eg. triamcinolone, betamethasone, fluocinonide, or clobetasol) and topical calcipotriene.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TEPMETKO (TEPOTINIB)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TERIFLUNOMIDE

Products Affected

- Teriflunomide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
Other Criteria	Documentation that teriflunomide is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TERIPARATIDE

Products Affected

- Bonsity
- Teriparatide

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

THALOMID (THALIDOMIDE)

Products Affected

- Thalomid CAPS 100MG, 50MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TIBSOVO (IVOSIDENIB)

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TICOVAC (TICK-BORNE ENCEPHALITIS VACCINE)

Products Affected

- Ticovac

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TIGECYCLINE

Products Affected

- Tigecycline

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TIROSINT (LEVOTHYROXINE ORAL SOLUTION)

Products Affected

- Tirosint-sol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Documentation of an inability to take solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOBI PODHALER (INHALED TOBRAMYCIN)

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOFACITINIB

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOLTERODINE

Products Affected

- Tolterodine Tartrate
- Tolterodine Tartrate Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: Initial: medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq), and prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects. Renewal: prescriber attestation that the benefits of therapy continue to outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOLVAPTAN

Products Affected

- Tolvaptan

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TONMYA (CYCLOBENZAPRINE)

Products Affected

- Tonmya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of fibromyalgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of two of the following: pregabalin, duloxetine, or amitriptyline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPICAL ACYCLOVIR

Products Affected

- Acyclovir CREA
- Acyclovir OINT

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Applies to acyclovir ointment only: for genital herpes or patient who are immunocompromised with non-life-threatening mucocutaneous herpes simplex infection, failure of oral acyclovir.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPICAL DICLOFENAC

Products Affected

- Diclofenac Sodium GEL 3%
- Diclofenac Sodium TOPICAL SOLN 1.5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) Cancer-related pain (diclofenac sodium solution only)
Exclusion Criteria	N/A
Required Medical Information	For diclofenac 3% gel only: medical record documentation of actinic keratosis. For diclofenac sodium solution: 1) Cancer related pain, initial: medical record documentation of cancer-related pain. 2) Osteoarthritis of the knee, initial: medical record confirmation of osteoarthritis of the knee.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Actinic keratosis: 90 days. All others: 12 months.
Other Criteria	Actinic keratosis, initial: failure of or contraindication to imiquimod and topical 5-fluorouracil.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPICAL PENCICLOVIR

Products Affected

- Penciclovir CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For recurrent herpes simplex labialis (oral herpes), failure of topical acyclovir cream.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPIRAMATE ORAL SOLUTION

Products Affected

- Topiramate SOLN 25MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to new starts only. Initial: Documentation of an inability to swallow oral dosage forms or contents of sprinkle capsules.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOREMIFENE

Products Affected

- Toremifene Citrate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, endocrinologist or neurologist. For chronic graft versus host disease, a transplant specialist. For systemic mast cell disease, an allergist or immunologist. For dermatofibrosarcoma protuberans, a dermatologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRELSTAR MIX (TRIPTORELIN)

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TREMFYA (GUSELKUMAB)

Products Affected

- Tremfya INJ 100MG/ML, 200MG/2ML
- Tremfya Induction Pack For Crohns Disease/ulcerative Colitis

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRETINOIN

Products Affected

- Tretinoin CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIKAFTA (ELEXACAFTOR-TEZACAFTOR-IVACAFTOR)

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRINTELLIX (VORTIOXETINE)

Products Affected

- Trintellix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of 1) a selective serotonin reuptake inhibitor (SSRI): such as fluoxetine, paroxetine, citalopram, escitalopram, sertraline, AND 2) venlafaxine or duloxetine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TROSPIUM

Products Affected

- Trospium Chloride
- Trospium Chloride Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The following criteria only applies to members 60 years of age and older: Initial: medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq), and prescriber attestation that the benefits of therapy outweigh the risks of anticholinergic adverse effects. Renewal: prescriber attestation that the benefits of therapy continue to outweigh the risks of anticholinergic adverse effects.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRULICITY (DULAGLUTIDE)

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of type 2 diabetes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUMENBA (MENINGOCOCCAL B VACCINE)

Products Affected

- Trumenba

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Between 10 years and 25 years of age
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUQAP (CAPIVASERTIB)

Products Affected

- Truqap TABS 200MG
- Truqap TBPK 160MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRYNGOLZA (OLEZARSEN)

Products Affected

- Tryngolza

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRYVIO (APROCITENTAN)

Products Affected

- Tryvio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of 1) blood pressure that is not adequately controlled on multiple blood pressure lowering medications and 2) that Tryvio will be prescribed in combination with other blood pressure lowering medications. Renewal: documentation of reduction in blood pressure from baseline.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, nephrologist or endocrinologist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: Failure of at least two of the following: 1) a beta blocker such as metoprolol, carvedilol, atenolol, 2) a calcium channel blocker such as amlodipine, nifedipine, diltiazem, verapamil, 3) an angiotensin receptor blocker or ACE inhibitor such as losartan or lisinopril, 4) a diuretic such as hydrochlorothiazide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TUKYSA (TUCATINIB)

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TURALIO (PEXIDARTINIB)

Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYMLOS (ABALOPARATIDE)

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

UBRELVY (UBROGEPANT)

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of two triptans, such as eletriptan, sumatriptan, naratriptan, rizatriptan, or zolmitriptan, unless there is documentation of intolerance or a contraindication to triptans.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

USTEKINUMAB BIOSIMILARS

Products Affected

- Steqeyma INJ 45MG/0.5ML, 90MG/ML
- Yesintek INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

UZEDY (RISPERIDONE ER)

Products Affected

- Uzedy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: trial of, intolerance to or contraindication to generic risperidone intramuscular injection (generic Risperdal Consta).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VALCHLOR (MECHLORETHAMINE)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VANFLYTA (QUIZARTINIB)

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VANRAFIA (ATRASENTAN)

Products Affected

- Vanrafia

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VAXCHORA (CHOLERA VACCINE)

Products Affected

- Vaxchora

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VENCLEXTA (VENETOCLAX)

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VEOZAH (FEZOLINETANT)

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record documentation of moderate to severe vasomotor symptoms due to menopause. Renewal: documentation of a reduction in severity of vasomotor symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	1) Failure of paroxetine. 2) Failure of or contraindication to systemic estrogen.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERKAZIA (CYCLOSPORINE)

Products Affected

- Verkazia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: documentation of an improvement in symptoms of vernal keratoconjunctivitis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VERQUVO (VERICIGUAT)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of 1) ejection fraction of less than 45%, 2) NYHA class II-IV, 3) a recent decompensation requiring hospitalization or a need for outpatient IV diuretics.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERSACLOZ (CLOZAPINE)

Products Affected

- Versacloz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Documentation of an inability to use clozapine oral disintegrating tablets.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERZENIO (ABEMACICLIB)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VIBERZI (ELUXADOLINE)

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VIGABATRIN

Products Affected

- Vigabatrin
- Vigafyde

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS) Initial: Requires use with another anticonvulsant as combination therapy.
Age Restrictions	Infantile Spasm: 2 years of age or younger
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug for the treatment of Complex Partial Seizures: Failure of adjunctive treatment with at least two of the following: topiramate, felbamate, gabapentin, lamotrigine, tiagabine, levetiracetam, oxcarbazepine, zonisamide or lacosamide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIJOICE (ALPELISIB)

Products Affected

- Vijoice

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VILAZODONE

Products Affected

- Vilazodone Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concomitant use of a MAOI or within 14 days after discontinuing a MAOI.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Documentation of failure of 1) a selective serotonin reuptake inhibitor such as paroxetine, fluoxetine, citalopram, escitalopram or sertraline and 2) venlafaxine or duloxetine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VITRAKVI (LAROTRECTINIB)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VONJO (PACRITINIB)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOQUEZNA DUAL PACK (AMOXICILLIN-VONOPRAZAN)

Products Affected

- Voquezna Dual Pak

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VOQUEZNA TRIPLE PACK (AMOXICILLIN-CLARITHROMYCIN-VONOPRAZAN)

Products Affected

- Voquezna Triple Pak

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VORANIGO (VORASIDENIB)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORICONAZOLE

Products Affected

- Voriconazole INJ 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, hematologist or oncologist.
Coverage Duration	Until end of plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOSEVI (SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR)

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder) with a NS5A inhibitor for genotype 1 to 6 and/or sofosbuvir without an NS5A inhibitor for genotype 1a and genotype 3 and 3) Documentation of presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOWST (FECAL MICROBIOTA SPORES)

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Documentation of at least 1 recurrent episode of c. difficile infection (CDI) with a positive stool test and 2) documentation that Vowst will be initiated within 2-4 days following completion of an antibiotic course of treatment for CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOXZOGO (VOSORITIDE)

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) diagnosis of achondroplasia confirmed by genetic testing with a mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene, and 2) open epiphyses. Renewal: medical record documentation of open epiphyses.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOYDEYA (DANICOPAN)

Products Affected

- Voydeya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: confirmation of a diagnosis of paroxysmal nocturnal hemoglobinuria via flow cytometry. Renewal criteria: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or an oncologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOYXACT (SIBEPRENLIMAB-SZSI)

Products Affected

- Voyxact

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VYNDAMAX (TAFAMIDIS)

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation confirming the diagnosis of either wild-type or hereditary transthyretin amyloid cardiomyopathy (ATTRwt-CM or hATTR-CM).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYVGART HYTRULO (EFGARTIGIMOD ALF-HYALUR-QVFC)

Products Affected

- Vyvgart Hytrulo INJ 1000MG/5ML; 10000UNIT/5ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WAINUA (EPLONTERSEN)

Products Affected

- Wainua

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WAKIX (PITOLISANT)

Products Affected

- Wakix

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WAYRILZ (RILZABRUTINIB)

Products Affected

- Wayrilz

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WEGOVY (SEMAGLUTIDE)

Products Affected

- Wegovy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) For reducing the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease, initial: a) Medical record documentation of established cardiovascular disease (such as prior stroke, myocardial infarction, or peripheral arterial disease). b) Body mass index of at least 25 kg/m2. 2) For treatment of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), initial: a) documentation of moderate to severe liver fibrosis (stage F2 or F3).
Age Restrictions	N/A
Prescriber Restrictions	For MASH: Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WELIREG (BELZUTIFAN)

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WINREVAIR (SOTATERCEPT-CSRK)

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XALKORI (CRIZOTINIB)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XCOPRI (CENOBAMATE)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: Failure of two of the following: carbamazepine, oxcarbazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, zonisamide, lacosamide and levetiracetam.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XDEMVY (LOTILANER)

Products Affected

- Xdemvy

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XERMELO (TELOTRISTAT)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XOLAIR (OMALIZUMAB)

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XOLREMDI (MAVORIXAFOR)

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) medical record documentation of a diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome, confirmed by molecular genetic testing or a bone marrow biopsy. 2) baseline absolute neutrophil count and absolute lymphocyte count. Renewal: medical record documentation of an increase in absolute neutrophil count and absolute lymphocyte count from baseline.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, immunologist or dermatologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XOSPATA (GILTERITINIB)

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XPOVIO (SELINEXOR)

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XROMI (HYDROXYUREA ORAL SOLUTION)

Products Affected

- Xromi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of sickle cell anemia with crisis.
Age Restrictions	6 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	For patients age 18 years and older: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XTANDI (ENZALUTAMIDE)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XYWAV (CALCIUM-MAGNESIUM-POTASSIUM-SODIUM OXYBATE)

Products Affected

- Xywav

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

YORVIPATH (PALOPEGTERIPARATIDE)

Products Affected

- Yorvipath

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: Prior to initiation of therapy, 25-hydroxyvitamin D stores is within normal range and serum calcium (albumin adjusted) greater than or equal to 7.8 mg/dL. Renewal criteria: maintenance of serum calcium (albumin-corrected) concentration in the low-normal range.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or nephrologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

YUTREPIA (TREPROSTINIL INHALATION CAPSULE)

Products Affected

- Yutrepia

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZAVESCA (MIGLUSTAT)

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZEJULA (NIRAPARIB)

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZELBORAF (VEMURAFENIB)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZELSUVMI (BERDAZIMER)

Products Affected

- Zelsuvmi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of molluscum contagiosum.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist.
Coverage Duration	12 weeks
Other Criteria	For patients 2 years of age or older: Failure of Ycanth.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEMAIRA/PROLASTIN (ALPHA 1-ANTITRYPSIN)

Products Affected

- Prolastin-c INJ 1000MG/20ML
- Zemaira INJ 1000MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) documented ZZ or Z/null AAT deficiency and 2) AAT serum level less than or equal to 11 micromoles/L or 50mg/dL and 3) moderate emphysema and/or FEV1 less than 80% and 4) the provider has outlined specific, measurable treatment goals such as slowing of FEV1 decline or lack of disease progression. Renewal: documentation patient is meeting treatment goals such as slowing FEV1 decline or lack of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: Medical record documentation of failure of or intolerance to Aralast or reason why Aralast cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZENBEXUS (IBERDOMIDE)

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZEPOSIA (OZANIMOD)

Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZILBRYSQ (ZILUCOPLAN)

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Medical record confirmation of a diagnosis of generalized myasthenia gravis (gMG) and anti-acetylcholine receptor (AChR) antibody positive status. Renewal: medical record documentation of a clinical response, such as improvement in function.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Failure of 1) pyridostigmine, and 2) an immunomodulator such as azathioprine, mycophenolate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZOKINVY (LONAFARNIB)

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of a diagnosis of Hutchinson-Gilford progeria syndrome (HGPS), or processing-deficient progeroid laminopathies (PLs) confirmed by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist or metabolic disorder specialist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOLINZA (VORINOSTAT)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation of the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Lifetime
Other Criteria	Drug must be prescribed for a FDA approved indication. If prescribed for non-cancer indication that is not FDA approved, the off-label use of the drug must be for a medically accepted indication that is supported by AHFS (American Hospital Formulary Service) Drug Information or Micromedex DrugDex. If prescribed for a cancer indication that is not FDA approved, the off-label use of the drug must be supported by NCCN (National Comprehensive Cancer Network) guidelines, AHFS (American Hospital Formulary Service) Drug Information, Micromedex DrugDex, Clinical Pharmacology, Lexi-Drugs, or research found in peer reviewed medical literature in accordance with Chapter 15 of the Medicare Benefit Policy Manual.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZONISADE (ZONISAMIDE ORAL SUSPENSION)

Products Affected

- Zonisade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on the drug: documentation of an inability to take solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZTALMY (GANAXOLONE)

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The following criteria applies to members who newly start on the drug: Medical record documentation confirming a diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZURZUVAE (ZURANOLONE)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Current pregnancy.
Required Medical Information	Medical record documentation of a diagnosis of postpartum depression.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYKADIA (CERITINIB)

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZYMFENTRA (INFLIXIMAB-DYYB)

Products Affected

- Zymfentra 2-pen
- Zymfentra 2-syringe

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PART B VERSUS PART D

Products Affected

- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Arformoterol Tartrate
- Azathioprine TABS
- Budesonide SUSP
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS 50MG
- Cyclosporine CAPS
- Cyclosporine Modified
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Heplisav-b
- Imovax Rabies (h.d.c.v.)

- Intralipid INJ 20GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Methotrexate INJ 50MG/2ML
- Methotrexate Sodium INJ 50MG/2ML
- Methotrexate Sodium TABS
- Methylprednisolone TABS
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myhibbin
- Nutrilipid
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG, 2.5MG, 20MG, 50MG, 5MG
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prograf PACK

- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tacrolimus Er
- Tobramycin NEBU 300MG/5ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

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