ABILIFY MYCITE

Products Affected

- Abilify Mycite Maintenance Kit
- Abilify Mycite Starter Kit

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 of the medical necessity of tracking compliance with the prescribed treatment regimen.
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.

ACTHAR HP

Products Affected

- Acthar
- Cortrophin INJ 80UNIT/ML

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, 7) Respiratory diseases such as symptomatic sarcoidosis or 8) 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

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

Products Affected

- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter
- Adalimumab-adbm
- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter INJ 0

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Active non-radiographic axial spondyloarthritis
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 4) Hidradenitis suppurativa (HS) initial: moderate to severe disease evident by documentation of Hurley Stage II or III. HS renewal: medical record documentation of a reduction in nodules or abscesses. 5) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 6) Psoriasis with arthropathy (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 7) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 8) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 0) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission. 10) Uveitis initial: documentation of non-infectious, intermediate, posterior or panuveitis. Renewal: documentation that treatment response is being monitored for the following development of new inflammatory chorioretinal and/or inflammatory retinal vascular lesions, anterior chamber cell grade or vitreous haze, or visual acuity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC, ophthalmologist for uveitis, rheumatologist for AS, nr-axSpA, JIA, RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.

Other Criteria	AS and nr-axSpA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA initial: failure of an 8 week trial of methotrexate. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization), and 2) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Atopic dermatitis initial (AD): body surface area involvement of at least 10% at baseline. 2) AD renewal criteria: medical record 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 a dermatologist, allergist, or immunologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Atopic dermatitis: failure of or contraindication to 1) one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and 2) tacrolimus ointment.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AGAMREE

Products Affected

- Agamree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: genetic testing results confirming a diagnosis of Duchenne muscular dystrophy. Renewal criteria: documentation of a positive treatment response (e.g. pulmonary function, muscle strength, functional ability, walk tests).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
Coverage Duration	12 months
Other Criteria	Failure of prednisone and deflazacort (requires PA).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: 1) Episodic migraine: 4-14 headache days per month, 2) Chronic migraines: 15 or more headache days per month with at least 8 days of migraines for 3 months. Migraine renewal criteria: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime
Other Criteria	Documentation that Aimovig will not be used with a second CGRP agent for migrane prevention.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALDURAZYME

Products Affected

- Aldurazyme

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) Diagnostic confirmation by presence of glycosaminoglycans (GAG) in the urine, deficiency in a-L-iduronidase enzyme activity, or genetic testing, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as improvement in percent predicted FVC, improvement in 6-minute walk test, reduction in urinary GAG levels, or reduction in liver size.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Dosing consistent with product label: 0.58 mg/kg IV once weekly.
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.

ALYFTREK

Products Affected

- Alyftrek

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 cystic fibrosis with at least one variant in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is either responsive based on clinical and/or in vitro data or results in production of CFTR protein. Renewal: Medical record documentation of treatment response such as an improvement in FEV1, reduction in pulmonary exacerbation, or improvement in respiratory symptoms.
Age Restrictions	6 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.

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 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

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: Documentation that the patient's off time has been reduced with apomorphine.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Initial: Documentation of failure of maximum tolerable doses of oral levodopa/carbidopa and one of the following: selegiline, ropinirole, pramipexole, entacapone and Ongentys (requires step therapy).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

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.

AQNEURSA

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

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 or hemoglobin analysis. 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 Reblozyl.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARALAST

Products Affected

- Aralast Np INJ 1000MG, 500MG

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

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Deficiency of Interleukin-1 Receptor Antagonist (DIRA) renewal: documentation of positive clinical response, such as low disease activity or improvement in signs and symptoms. 2) Recurrent pericarditis, renewal: documentation that pericarditis has not recurred. 3) Cryopyrin associated periodic syndrome, renewal: documentation of positive clinical response, such as a reduction in joint pain, resolution of rash, improvement in fatigue.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: an immunologist or a geneticist for DIRA, or a cardiologist for recurrent pericarditis.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For Deficiency of Interleukin-1 Receptor Antagonist (DIRA): failure of Kineret (requires PA).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation that Arikacye will be used as part of combination antibacterial drug regimen, and either positive sputum culture or lack of clinical signs of improvement (such as anemia, fever, or lack of reduction in nodule size).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, HIV specialist or pulmonologist.
Coverage Duration	6 months
Other Criteria	Failure of at least 6 consecutive months of a multidrug regimen (such as combination of the following agents: azithromycin or clarithromycin, ethambutol, rifabutin, clofazimine).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARISTADA

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 Abilify 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.

ASTAGRAF

Products Affected

- Tacrolimus 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	Lifetime
Other Criteria	To prevent or treat an organ transplant rejection, Part B versus D determination will be made to determine coverage. If the drug is to be covered by Part D and the patient is newly started on tacrolimus ER capsule, failure of tacrolimus immediate release or reason why tacrolimus immediate release cannot be used is required.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ATTRUBY

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.

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded in patients with suicidality, hepatic impairment, inadequately treated depression, concomitant use of MAOIs and reserpine.
Required Medical Information	Renewal criteria: 1) For Huntington's disease (HD): medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, and increase in quality of life. 2) For tardive dyskinesia (TD): medical record documentation of treatment response such as a reduction in the AIMS score from baseline, improvement in involuntary movement, or improvement in functional ability
Age Restrictions	For tardive dyskinesia (TD): 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with: neurologist for HD, neurologist, movement disorder specialist or a psychiatrist for TD.
Coverage Duration	HD Initial: 6 months. TD Initial: 6 months. Renewal for HD and TD: 12 months.
Other Criteria	Initial criteria for HD: failure of or contraindication to tetrabenazine (requires prior authorization). Initial criteria for TD: failure of or contraindication to tetrabenazine and Ingrezza (both require prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AUVELITY

Products Affected

- Auvelity TBCR 105MG; 45MG
- Auvelity Titration Pack

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 Auvelity: medical record documentation of 1) a diagnosis of major depressive disorder, or 2) agitation associated with dementia due to Alzheimer disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	The following criteria applies to members who newly start on Auvelity for major depressive disorder only: medical record documentation of trial of, intolerance to or contraindication to: a) bupropion and b) an SSRI or SNRI such as sertraline, fluoxetine, escitalopram, paroxetine, venlafaxine, or duloxetine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BEMPEDOIC ACID

Products Affected

- Nexletol
- Nexlizet

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Primary hyperlipidemia, initial: documentation of LDL-C greater than 100 mg/dL without cardiovascular disease, or greater than 55 mg/dL with cardiovascular disease. Primary hyperlipidemia, renewal: a) continued treatment with statins unless intolerant or contraindicated, and 2) LDL reduction from baseline. 2) For reducing cardiovascular (CV) event risk, initial: documentation of statin intolerance AND one of the following a) existing cardiovascular disease such as coronary artery disease, symptomatic peripheral arterial disease, and/or cerebrovascular atherosclerotic disease, OR b) high risk of a cardiovascular event.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
Coverage Duration	Primary hyperlipidemia: Initial: 6 months, Renewal: lifetime. Reducing CV event risk: lifetime.
Other Criteria	For all indications, initial: 1) Medical record documentation of failure of, significant side effect from, contraindication, or intolerance to one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis. 2) Failure of Repatha or Praluent. Both require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe active CNS lupus or used in combination with other biologics or IV cyclophosphamide
Required Medical Information	1) Systemic lupus erythematosus initial criteria: a) Medical record documentation of a diagnosis of systemic lupus erythematosus (SLE) and is auto-antibody positive as defined as Antinuclear antibody (ANA titer) greater than or equal to 1:80 or anti-double stranded DNA antibody (Anti-dsDNA) greater than or equal to 30 IU/ml. b) Receiving standard therapy including NSAIDs, antimalarials, corticosteroids or immunosuppressants. Renewal criteria: medical record documentation of treatment response such as an improvement in the SELENA-SLEDAI score or no worsening of disease activity. 2) Active lupus nephritis initial criteria: a) Medical record documentation of a diagnosis of active lupus nephritis. b) Receiving standard therapy including corticosteroids or immunosuppressants. Renewal: medical record documentation of treatment response such as stabilization of eGFR or no worsening of disease activity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist 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.

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.

BEXSERO

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Concomitant administration with cyclosporine A or glyburide. 2) Pregnancy.
Required Medical Information	Documentation of New York Heart Association (NYHA) Class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Lifetime
Other Criteria	The following does not apply to pediatric members with idiopathic/congenital pulmonary arterial hypertension: Failure of or contraindication to sildenafil or tadalafil (both require prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BOTULINUM TOXINS

Products Affected

- Botox
- Xeomin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Chronic migraine (For Botox only): a) Initial: at least 15 days of headache lasting 4 hours a day or longer. b) Renewal: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine. 2. Urinary incontinence (For Botox only) renewal criteria: documentation of treatment response including a decrease in the number of incontinence episodes or frequency. 3. Chronic sialorrhea: Renewal criteria (For Xeomin only): documentation of treatment response such as an improvement in drooling severity, drooling frequency, or improvement in the Global Impression of Change Scale. 4) Renewal criteria for all other diagnoses: documentation of treatment response including a decrease in the severity of dystonia, decrease in pain, or decrease in disability.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Xeomin (chronic sialorrhea): 12 months, 3 dose series. All other diagnoses: 12 months, 4 dose series
Other Criteria	1) Migraine prophylaxis (For Botox only): failure of propranolol and topiramate. 2) Urinary incontinence (For Botox only): failure of two oral anticholinergics such as oxybutynin, tolterodine, or solifenacin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRINSUPRI

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	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 brivaracetam tablets or suspension. For tabs: 1) failure of levetiracetam, and 2) in patients one month of age and older, failure of one of the following: carbamazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, oxcarbazepine, lacosamide, or zonisamide. For suspension: 1) inability to swallow oral dosage forms, 2) failure of levetiracetam suspension, and 3) in patients one month of age and older, failure of one of the following suspensions or solutions: carbamazepine, phenytoin, felbamate, oxcarbazepine, gabapentin, or lacosamide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIVIACT

Products Affected

- Briviact INJ

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 Briviact tablets or suspension. For tabs: medical record documentation of failure of 1) levetiracetam and 2) one of the following: carbamazepine, phenytoin, topiramate, divalproex, felbamate, tiagabine, lamotrigine, gabapentin, oxcarbazepine, lacosamide, or zonisamide. For suspension: 1) medical record documentation of failure of a) levetiracetam suspension and b) one of the following suspensions or solutions: carbamazepine, phenytoin, felbamate, oxcarbazepine, gabapentin, or lacosamide, and 2) inability to swallow oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRONCHITOL

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Failure of bronchitol tolerance test.
Required Medical Information	Initial: confirmation of a diagnosis of cystic fibrosis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Lifetime
Other Criteria	N/A
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

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.

CAMZYOS

Products Affected

- Camzyos

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 50% and 2) improvement in symptoms or functioning.
Age Restrictions	N/A
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.

CANCER DRUGS

Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega
- Abraxane
- Akeega
- Alecensa
- Aliqopa
- Alunbrig
- Augtyro
- Avastin
- Avmapki Fakzynja Co-pack
- Ayvakit
- Balversa
- Bavencio
- Beleodaq
- Bendamustine Hydrochloride INJ 100MG, 25MG
- Besremi
- Besremi Pen
- Bexarotene
- Bortezomib INJ 3.5MG
- Bosulif CAPS
- Bosulif TABS 100MG, 500MG
- Bosutinib
- Braftovi CAPS 75MG
- Brukinsa
- Busulfan
- Cabometyx
- Calquence TABS
- Caprelsa
- Carmustine INJ 100MG
- Cavhanza
- Clofarabine
- Cometriq
- Copiktra
- Cotellic
- Cyramza
- Dactinomycin
- Danziten
- Darzalex
- Darzalex Faspro
- Dasatinib
- Daurismo

- Docetaxel INJ 160MG/16ML, 160MG/8ML, 20MG/2ML, 20MG/ML, 80MG/4ML, 80MG/8ML
- Empliciti
- Ensacove
- Erbitux
- Eribulin Mesylate
- Erivedge
- Erleada
- Erlotinib Hydrochloride TABS
- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Everolimus TBSO
- Exkivity
- Firmagon INJ 120MG/VIAL, 80MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Folotyn
- Fotivda
- Fruzaqla
- Fulvestrant
- Gavreto
- Gefitinib
- Gilotrif
- Gomekli
- Hernexeos
- Hyrnuo
- Ibrance
- Iclusig
- Idarubicin Hcl
- Idarubicin Hydrochloride
- Idhifa
- Imatinib Mesylate TABS
- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 280MG, 420MG
- Imfinzi
- Inluriyo
- Inlyta
- Inqovi
- Itovebi
- Iwilfin
- Jakafi

- Jakafi Xr
- Jaypirca
- Jevtana
- Keytruda INJ 100MG/4ML
- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose
- Komzifti
- Koselugo CAPS
- Krazati
- Kyprolis
- Lapatinib Ditosylate
- Lazcluze
- Lenalidomide
- 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
- Libtayo
- Lifyorli
- Lonsurf
- Lorbrena
- Lumakras
- Lynparza TABS
- Lytgobi
- Mekinist
- Mektovi
- Melphalan Hydrochloride
- Mitomycin INJ 20MG, 40MG, 5MG
- Modeyso
- Mutamycin
- Mylotarg
- Nelarabine
- Nilotinib Hydrochloride
- Ninlaro
- Nipent
- Nubeqa
- Odomzo
- Ogsiveo

- Ojemda
- Ojjaara
- Onureg
- Opdivo
- Orserdu
- Paclitaxel Protein-bound Particles INJ 900MG; 100MG
- Pazopanib Hydrochloride
- Pemazyre
- Pemetrexed INJ 100MG, 500MG
- Pemetrexed Disodium
- Perjeta
- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose
- Pomalidomide
- Pralatrexate
- Proleukin
- Qinlock
- Retevmo TABS
- Revuforj
- Rezlidhia
- Romidepsin INJ 10MG
- Romvimza
- Rozlytrek CAPS
- Rubraca
- Rydapt
- Scemblix
- Sorafenib
- Sorafenib Tosylate TABS
- Stivarga
- Sunitinib Malate
- Tabrecta
- Tafinlar
- Tagrisso
- Talzenna
- Tazverik
- Tecentriq
- Tecentriq Hybreza
- Temsirolimus
- Tepmetko
- Tevimbra INJ 100MG/10ML
- Thiotepa INJ 15MG
- Tibsovo

- Toremifene Citrate
- Trelstar Mixject
- Tretinoin CAPS
- Truqap
- Tukysa
- Turalio CAPS 125MG
- Valchlor
- Vanflyta
- Vectibix INJ 100MG/5ML, 400MG/20ML
- Venclexta
- Venclexta Starting Pack
- Verzenio
- Vitrakvi
- Vizimpro
- Vonjo
- Voranigo
- Vyxeos
- Welireg
- Xalkori
- Xospata
- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly
- Xtandi
- Yervoy
- Yondelis
- Yonsa
- Yulithira
- Zaltrap
- Zanosar
- Zejula TABS
- Zelboraf
- Zenbexus
- Zolinza
- Zydelig
- Zykadia 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, 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.

CAPLYTA

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.

CARBAGLU

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A) For hyperammonemia type III, Initial: 1) Diagnosis confirmed by DNA testing and 2) Objective, measurable treatment goals are provided. B) For hyperammonemia due to propionic acidemia or methylmalonic acidemia, Initial: medical record documentation of the diagnosis. Renewal for all indications: 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: 3 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CARDAMYST

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). 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

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

Products Affected

- Cerdelga

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) Diagnostic confirmation by one of the following: a) biochemical assay showing decreased glucocerebrosidase activity in white blood cells or skin fibroblasts or b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene, and 2) Signs and symptoms that are severe enough to result in one or more of the following conditions: moderate-to-severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly, and 3) Documentation from a FDA-cleared test that the patient is an extensive, intermediate or poor CYP2D6 metabolizer and 4) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as 1) Improvement in hematologic markers, such as increased hemoglobin, hematocrit, or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For CYP2D6 extensive and intermediate metabolizers, the dose should not exceed 84mg twice daily. For CYP2D6 poor metabolizers, the dose should not exceed 84mg daily.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CEREZYME

Products Affected

- Cerezyme

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) Diagnostic confirmation by one of the following: a) biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity or b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene, and 2) Signs and symptoms that are severe enough to result in one or more of the following conditions: moderate-to-severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly, and 3) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as 1) Improvement in hematologic markers, such as increased Hgb/Hct and/or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label. Dose range: 2.5/kg IV 3 times weekly to 60 units/kg IV every 2 weeks. Usual dosage is 60 units/kg IV every 2 weeks.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medical record documentation that the patient is not a candidate for laparoscopic cholecystectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of ursodiol.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CHOLBAM

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

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Crohn's Disease (CD) initial: moderate to severe disease activity. CD renewal: medical record documentation of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 4) polyarticular juvenile idiopathic arthritis (pJIA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 7) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD, rheumatologist for AS, nr-axSpA, pJIA, RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS initial: failure of or contraindication to two of the following: adalimumab, Enbrel, Simponi, Cosentyx, or Xeljanz. All require prior authorization. Active nr-axSpA initial: failure of two of the following: adalimumab, Cosentyx, Rinvoq. All require prior authorization. CD initial: failure of two of the following: adalimumab, ustekinumab, Skyrizi, Rinvoq. pJIA initial: Failure of or contraindication to two of the following: adalimumab, Orencia. PsA initial: failure of or contraindication to two of the following: adalimumab, Enbrel, Simponi, Orencia, Otezla, Cosentyx, Skyrizi, ustekinumab, Rinvoq, or Xeljanz (IR or XR). PsO initial: failure of or contraindication to two of the following: adalimumab, Enbrel, ustekinumab, Otezla, Cosentyx, Skyrizi. RA initial: failure of or contraindication to two of the following: adalimumab,

	Enbrel, Simponi, Actemra, Orencia, Rinvoq, or Xeljanz (IR or XR). All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

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

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.

COLONY STIMULATING FACTORS

Products Affected

- Fulphila
- Granix INJ 300MCG/0.5ML, 300MCG/ML, 480MCG/0.8ML
- Leukine INJ 250MCG
- Neulasta
- Stimufend
- Udenyca
- Udenyca Onbody
- Zarxio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) AIDS Neutropenia (Leukine) and 2) Myelodysplastic Syndromes (Leukine)
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 (Leukine and Zarxio only), or acute exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome) (for Neulasta, Leukine, Stimufend, Udenyca, and Zarxio only), 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.

CORLANOR

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

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

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of nr-axSpA. 3) Enthesitis-related arthritis (ERA) renewal: improved functioning and/or signs and symptoms of ERA. 4) Hidradenitis suppurativa (HS): initial: moderate to severe disease evident by documentation of Hurley Stage II or III and at least 3 abscesses or inflammatory nodules. HS renewal: reduction in nodules and abscesses. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, nr-axSpA, ERA, RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS, nr-axSpA and active ERA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRENESSITY

Products Affected

- Crenessity

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

Products Affected

- Cresemba

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

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

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.

CYSTADANE

Products Affected

- Betaine Anhydrous

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 diagnostic confirmation such as by measurement of plasma and urine homocysteine levels. Renewal: Medical record documentation of stabilization of disease, such as decrease in plasma and urine homocysteine levels, improvement in neurological and neuromuscular function.
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.

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of seizure or moderate or severe renal impairment defined as creatinine clearance less than or equal to 50 mL/min.
Required Medical Information	Initial criteria: medical record documentation of 1) Diagnosis of multiple sclerosis, and 2) Prior to initiation of therapy, the patient must have a timed 25-foot walk time to establish a baseline to evaluate treatment response. Renewal criteria: 1) Medical record documentation of an improvement in the timed 25-foot walk time compared to baseline maximum walk speed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
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.

DAWNZERA

Products Affected

- Dawnzera

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 a reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks or clinical documentation of functional improvement.
Age Restrictions	12 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, allergist or immunologist.
Coverage Duration	Long term prevention, initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: failure of, intolerance to, or contraindication to Takhzyro (requires prior authorization). Initial and renewal: not using concurrently with other prophylaxis medications such as Takhzyro, Heagarda, Orladeyo, or Cinryze.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DAYBUE

Products Affected

- Daybue
- Daybue Stix

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 Rett syndrome. Renewal: Medical record documentation of maintenance or improvement of symptoms.
Age Restrictions	N/A
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.

DEFLAZACORT

Products Affected

- Deflazacort
- Jaythari
- Kymbee
- Pyquvi

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 genetic testing confirmation of Duchenne muscular dystrophy. Renewal criteria: documentation of either a) a positive treatment response (e.g. pulmonary function, muscle strength, functional ability, walk tests), or b) slowing of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
Coverage Duration	12 months
Other Criteria	Failure of or adverse effects to prednisone.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DENGVAXIA

Products Affected

- Dengvaxia

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 laboratory confirmed previous dengue infection. 2) Documentation of residence in an endemic area.
Age Restrictions	Between 9 years and 16 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.

DIACOMIT

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.

DIFICID

Products Affected

- Dificid SUSR

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

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

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Chronic immune thrombocytopenia (ITP): Initial criteria: Medical record documentation of platelet count less 30,000 per mm3. Renewal criteria: Medical record documentation of maintenance of platelet counts between 30,000 per mm3 and 150,000 per mm3 or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) Chronic liver disease with thrombocytopenia: Platelets less than 50k.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, a hematologist, or a surgeon.
Coverage Duration	ITP: Initial 6 weeks, Renewal 24 weeks. Chronic liver disease with thrombocytopenia: 5 days.
Other Criteria	Chronic immune thrombocytopenia: insufficient response to prior treatment with one of the following, a systemic corticosteroid or an immunoglobulin replacement. Chronic liver disease with thrombocytopenia: Documentation of upcoming procedure.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DOPTELET SPRINKLE

Products Affected

- Doptelet Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Chronic immune thrombocytopenia (ITP): Initial criteria: Medical record documentation of platelet count less 30,000 per mm3. Renewal criteria: Medical record documentation of maintenance of platelet counts between 30,000 per mm3 and 150,000 per mm3 or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) Chronic liver disease with thrombocytopenia: Platelets less than 50k.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, a hematologist, or a surgeon.
Coverage Duration	ITP: Initial 6 weeks, Renewal 24 weeks. Chronic liver disease with thrombocytopenia: 5 days.
Other Criteria	Chronic immune thrombocytopenia: insufficient response to prior treatment with one of the following, a systemic corticosteroid or an immunoglobulin replacement. Chronic liver disease with thrombocytopenia: Documentation of upcoming procedure. For all indications: Inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DRIZALMA

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

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Atopic dermatitis initial (AD): BSA involvement of 10% or more. AD renewal: positive treatment response, ie a reduction in BSA involvement, improvement in itching or functional ability, reduction in the IGA or EASI score. 2) Moderate to severe asthma, initial: a) documentation of eosinophilic phenotype with eosinophil count greater than or equal to 150 cells/mcL OR that chronic oral steroid use is required for asthma control. Moderate to severe asthma, renewal: reduction in oral steroid use or in asthma symptoms. 3) Chronic rhinosinusitis with nasal polyposis (CR) initial: medical record documentation that a) the condition is inadequately controlled and b) that Dupixent will be used as add-on therapy. CR renewal: treatment response such as reduction in steroid use or need for surgery. 4) Eosinophilic type COPD (E-COPD) initial: eosinophil count of at least 300 cells/mcL. E-COPD Renewal: Improvement in symptoms or less exacerbations. 5) Eosinophilic esophagitis (EE) initial: a) documentation eosinophilic esophagitis confirmed by symptoms related to esophageal dysfunction and biopsy showing eosinophil-predominant inflammation (ie as a peak value of f ≥15 eosinophils per high power field (HPF) or 60 eosinophils per mm2. b) weight of at least 15kg. EE renewal: clinical response, such as improvement in dysphagia or histologic remission. 6) Prurigo nodularis (PN), renewal: clinical response such as an improvement in pruritis or functioning or a reduction in nodular lesions. 7) Bullous pemphigoid (BP) initial: histopathological confirmation of BP and use in combo with steroids. Renewal: improvement such as remission or decrease in lesions. 7) Urticaria initial: symptoms for at least 6 weeks. Renewal: clinical response such as decrease in symptoms. 8) Allergic fungal rhinosinusitis, initial: history of surgery, nasal polyposis, CT with hyperdensities, bony demineralization or bone erosion, and IgE or skin testing confirming fungal allergy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist, allergist or immunologist for AD, pulmonologist or allergist for asthma or E-COPD, ENT or otolaryngologist for CR or allergic fungal rhinosinusitis, gastroenterologist for EE.

Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Atopic dermatitis, initial: For patients 12 years of age or older: 1) failure of one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and 2) failure of tacrolimus ointment, OR documentation that topical prescription therapies are not appropriate or are contraindicated. Moderate to severe asthma, eosinophilic phenotype or oral corticosteroid dependent, initial: trial and failure of an ICS+LABA combo such as fluticasone/vilanterol or fluticasone/salmeterol. Eosinophilic type uncontrolled COPD, initial: exacerbations while on triple therapy with an ICS + LAMA + LABA combo such as Trelegy or Breztri. Allergic fungal rhinosinusitis, initial: failure of a nasal steroid such as flunisolide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUVYZAT

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: genetic testing results confirming a diagnosis of Duchenne muscular dystrophy. Renewal criteria: documentation of a slowing of disease progression.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy or neuromuscular disorders.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EBGLYSS

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Atopic dermatitis initial (AD): 1) documentation showing moderate to severe atopic dermatitis and 2) documentation AD is not adequately controlled with topical therapies such as clobetasol or tacrolimus, or that topical therapies are not advisable. AD renewal: medical record 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: dermatologist, allergist or immunologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EGRIFTA

Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, or head irradiation or trauma, 2) malignancy, active (either newly diagnosed or recurrent), malignancies should be inactive and completely treated prior to initiating therapy, 3) Pregnancy, 4) Body mass index less than or equal to 20 kg/m2. 5) Not approved for use in patients without HIV infection.
Required Medical Information	Initial criteria: 1) Lipodystrophy defined as a) For men: a waist circumference of greater than or equal to 95 cm or 37.5 inches or a waist-to-hip ratio of greater than or equal to 0.94 and b) For women: a waist circumference of greater than or equal to 94 cm or 37 inches or a waist-to-hip ratio of greater than or equal to 0.88. 2) Currently on anti-retroviral therapy. Renewal criteria: documentation of treatment response such as reduction in visceral adipose tissue as demonstrated from waist circumference or CT scan.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or HIV specialist.
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.

EKTERLY

Products Affected

- Ekterly

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 by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal OR c) Normal C1-INH levels and one of the following: i) Confirmed presence of variant(s) in the gene(s) for FXII (F12), angiopoietin-1 (ANGPT1), plasminogen (PLG), kininogen-1 (KNG1), myoferlin (MYOF), and heparan sulfate-glucosamine 3-Osulfotransferase 6 (HS3ST6) OR ii) Recurring angioedema attacks that are refractory to high-dose antihistamines. Renewal criteria for long-term prevention: Documentation of a reduction in symptoms such as abdominal pain, cutaneous pain and cutaneous swelling.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist, hematologist or immunologist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: Failure of or contraindication to icatibant.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ELAPRASE

Products Affected

- Elaprase

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) Diagnostic confirmation of by such as presence of glycosaminoglycans (GAG) in the urine, deficiency in iduronate-2-sulfatase enzyme activity, or genetic testing, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression, such as improvement in percent predicted FVC, improvement in 6-minute walk test, reduction in urinary GAG levels, or reduction in liver or spleen size.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: 0.5mg/kg IV once weekly.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELIQUIS

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.

ELTROMBOPAG

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Persistent or chronic immune (idiopathic) thrombocytopenic purpura (ITP) initial: medical record documentation of platelet count less 30,000 per mm3. ITP Renewal: maintenance of platelet counts between 30,000 per mm3 and 150,000 per mm3 or an increase in platelet counts from baseline with resolution of bleeding episodes. 2) thrombocytopenia in patients with chronic Hepatitis C (Hep C thrombocytopenia), initial: a) platelets less than 75,000 per mm3. b) request to treat thrombocytopenia to allow initiation of interferon-based therapy. Hep C thrombocytopenia renewal: medical record documentation that platelets have increased since initiating eltrombopag. 3) Aplastic anemia (AA) initial: platelets counts less than or equal to 30,000 per mm3. AA renewal: maintenance of platelet counts between 30,000 per mm3 and 150,000 per mm3 or an increase in platelet counts from baseline.
Age Restrictions	1 year of age or older
Prescriber Restrictions	Prescribed by or in consultation with: hematologist or oncologist for AA and ITP, hematologist, hepatologist, gastroenterologist, infectious disease specialist or oncologist for Hep C thrombocytopenia.
Coverage Duration	ITP: Initial 6wk, Renew 6mo. HepC, thrombo: Initial 3mo, Renew 12mo. AA: Initial 4mo, Renew 12mo.
Other Criteria	The following criteria only applies to persistent or chronic immune (idiopathic) thrombocytopenia: documentation of disease refractory to the following: systemic corticosteroids, immunoglobulin replacement or splenectomy. For suspension: documentation of an inability to swallow solid oral dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic cluster headache: 1) Initial: medical record documentation of the diagnosis and that the patient has experienced at least 2 cluster periods from 7 to 365 days, separated by pain free periods lasting at least 3 months. 2) Renewal: documentation of treatment response including a reduction in headaches, decreased abortive medication use, or emergency room visits. 3) Not used in combination with another CGRP inhibitor. Migraines: 1) Initial: episodic migraine, 4-14 headache days per month. Chronic migraines, 15 or more headache days per month with at least 8 days of migraines for 3 months. 2) Renewal: documentation of treatment response including decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Documentation that Emgality will not be used with a second CGRP agent for migraine prevention.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMPAVELI

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Paroxysmal nocturnal hemoglobinuria (PNH): medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria confirmed by high-sensitivity flow-cytometry. PNH Renewal: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline. 2) C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN): medical record documentation of the diagnosis confirmed by biopsy, proteinuria greater than or equal to 1 g/day and spot urine protein-to-creatinine ratio greater than or equal to1 g/g. Renewal: clinical benefit such as reduction in proteinuria.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with a nephrologist, 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.

EMSAM

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

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) Renewal: Improved functioning and/or symptoms. 2) Juvenile idiopathic arthritis (JIA) and juvenile psoriatic arthritis (JPsA) renewal: Improved functioning and/or improvement in tender joint count and swollen joint count. 3)Psoriatic arthritis (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 5) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, JIA, JPsA, RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS initial: failure of one oral non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA and JPsA initial: failure of methotrexate for at least 8 weeks. PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine. RA Initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENDARAVONE

Products Affected

- Radicava Ors
- 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

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.

ENSPRYNG

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

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical 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	CD initial: Failure of two of the following: adalimumab, ustekinumab, Rinvoq, Simponi, Skyrizi. All require prior authorization. UC Initial: Failure of two of the following: adalimumab, ustekinumab, Rinvoq, Simponi, Skyrizi and Xeljanz. All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EOHILIA

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

Products Affected

- Epidiolex

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 all diagnoses: Epidiolix must be used as adjunctive treatment. 2) For Lennox-Gastaut Syndrome: failure of two of the following: clonazepam, valproate, topiramate, lamotrigine, felbamate or rufinamide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERYTHROPOIESIS-STIMULATING AGENTS

Products Affected

- Procrit
- Retacrit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Anemia associated with chronic kidney disease (CKD): a) Hgb below 10 g/dL or Hct below 30% and b) ferritin at least 100 ng/mL and/or c) transferrin saturation at least 20%. 2) Anemia associated with cancer treatment for non-myeloid cancers: a) Hgb below 10 g/dL or Hct below 30% and b) ferritin at least 100 ng/mL and/or c) transferrin saturation at least 20%. 3) Anemia associated with Zidovudine therapy in HIV/AIDS: a) Hgb below 10 g/dL or Hct below 30% and b) transferrin saturation at least 20%, and c) endogenous erythropoietin below 500 IU/L, 4) Surgery: a) high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery and b) baseline Hgb greater than 10g/dL, but below 13g/dL. Renewal criteria for 1-3: transferrin saturation greater than 20%.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD and HIV: 12 months. Cancer: 6 months. Surgery: 1 month.
Other Criteria	1) Anemia associated with zidovudine therapy: zidovudine dose less than 4200mg per week verified by claim history. 2) For end stage renal disease (ESRD) patients on dialysis, 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 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

Products Affected

- Evenity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Stroke or myocardial infarction in the last 12 months. 2) Uncorrected hypocalcemia.
Required Medical Information	Medical record documentation of high risk or very high risk of fracture defined as a history of osteoporotic fracture, or multiple risk factors for fracture (such as bone mineral density less than -2.5, previous minimal trauma fracture as an adult, low weight or body mass index, history of hip fracture in a first degree relative, tall stature or use of tobacco). Very high risk of fracture is defined as recent fracture (within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm such as long term steroids, very low T-score such as less than -3, high risk of falls or history of injurious falls, and very high fracture probability determined by the Fracture Risk Assessment Tool (FRAX).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months maximum. Use is not recommended for longer.
Other Criteria	The following criteria do not apply if considered very high risk for fracture: Failure of or contraindication to 1) oral bisphosphonates and 2) Prolia.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVRYSDI

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.

EXONDYS

Products Affected

- Exondys 51

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 confirmed mutation of the Duchenne muscular dystrophy (DMD) gene that is amenable to exon 51 skipping. Renewal criteria: Documentation of an improvement in symptoms including distance that a patient can walk on a flat, hard surface in a period of 6 minutes and/or reduction in disease progression.
Age Restrictions	N/A
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.

EXXUA

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

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Paroxysmal nocturnal hemoglobinuria (PNH): medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria. PNH Renewal: medical record documentation of clinical benefit, such as increase in hemoglobin level from baseline. 2) Primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN. b) laboratory results confirming proteinuria. IgAN renewal: medical record documentation of clinical benefit, such as a decrease in urine protein-to-creatinine ratio from baseline. 3) C3 glomerulopathy (C3G): medical record documentation of the diagnosis confirmed by biopsy and spot urine protein-to-creatinine ratio greater than or equal to1 g/g. Renewal: clinical benefit such as reduction in proteinuria.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: hematologist or oncologist for PNH, nephrologist for IgAN.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	IgAN: documentation of failure of or contraindication to Filspari (requires prior authorization) OR Vanrafia (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FABRAZYME

Products Affected

- Fabrazyme

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) For males, diagnostic confirmation of a-galactosidase levels (a- GAL) of less than 1.5 nmol/hr/ml on plasma or less than 4nmol/hr/mg in leukocytes. For females, diagnostic confirmation based on low leukocyte a- GAL A or family history of genetic mutation analysis of the a- GAL A gene or characteristic findings e.g., angiokeratomas, telangiectasias, severe neuropathic pain and organ involvement, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization or slowing of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: 1 mg/kg IV infusion every 2 weeks.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma initial criteria: 1) Medical record documentation of a diagnosis of severe asthma with eosinophilic phenotype and 2) Blood eosinophil levels greater than or equal to 150 cells/mcL in the last 4 weeks. Asthma renewal criteria: documentation of or claims history showing a reduction in the use of oral steroids or reduction in asthma symptoms. Eosinophilic granulomatosis with polyangiitis (EGPA) initial: 1) diagnosis confirmed by documentation of asthma, and 2) blood eosinophil level of 10% or an absolute count of greater than 1000 cells/mm3. EGPA renewal criteria: documentation of response to treatment such as achievement of remission, decrease in the use of steroids, decrease in the rate of relapses or improvement in asthma symptoms. Hypereosinophilic syndrome (HES) initial: Medical record documentation showing that the diagnosis has a duration of at least 6 months, and does not have an identifiable nonhematologic secondary cause. Renewal: documentation of reduction in flares, or other clinical benefit from Fasenra.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for asthma, rheumatologist, pulmonologist, immunologist or vasculitis specialist for EGPA, hematologist or immunologist for HES.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Asthma, initial: failure of an inhaled corticosteroid and a long-acting beta agonist.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FETZIMA

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.

FIDAXOMICIN

Products Affected

- 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	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FILSPARI

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	For focal segmental glomerulosclerosis: active diagnosis of nephrotic syndrome
Required Medical Information	Immunoglobulin A nephropathy (IgAN) initial: 1) medical record documentation of biopsy confirmed primary immunoglobulin A nephropathy. Renewal: medical record documentation of a decrease in urine protein-to-creatinine ratio from baseline. Focal segmental glomerulosclerosis (FSGS) initial: 1) diagnosis of FSGS confirmed by genetic testing or biopsy. 2) Submission of baseline urine protein-to-creatinine ratio. Renewal: medical record documentation of a decrease in urine protein-to-creatinine ratio from baseline.
Age Restrictions	FSGS: 8 years of age or older. IgAN: 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
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.

FILSUVEZ

Products Affected

- Filsuvez

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 genetic testing confirmation of junctional epidermolysis bullosa (JEB) or dystrophic epidermolysis bullosa (DEB). Renewal: medical record documentation of clinical response (i.e. wound healing).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or wound care specialist.
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.

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

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

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of seizure
Required Medical Information	Initial: Confirmation of a diagnosis of Lambert-Eaton myasthenic syndrome via EMG or antibody testing. Renewal: Documentation of a treatment response such as a reduction in muscle weakness or functional impairment.
Age Restrictions	6 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.

GALAFOLD

Products Affected

- Galafold

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) For males, diagnostic confirmation of a-galactosidase levels (a- GAL) of less than 1.5 nmol/hr/ml on plasma or less than 4nmol/hr/mg in leukocytes. For females, diagnostic confirmation based on low leukocyte a- GAL A or family history of genetic mutation analysis of the a- GAL A gene or characteristic findings e.g., angiokeratomas, telangiectasias, severe neuropathic pain and organ involvement, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization or slowing of disease progression.
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.

GARDASIL

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

Products Affected

- Gattex

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 that the patient is dependent on parenteral support. Renewal criteria: Medical record documentation of a decrease in parenteral support such as a decrease in volume and/or frequency.
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 require use of a prerequisite Part D drug.

GEMTESA

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.

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.

GRANISETRON

Products Affected

- Granisetron Hcl INJ 1MG/ML
- Granisetron Hydrochloride
- Granisol

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.

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) 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. 2) 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 criteria for long term prevention: Documentation of a reduction in the number of angioedema attacks, improvement in the severity and duration of attacks or clinical documentation of functional improvement.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist, hematologist 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.

HETLIOZ

Products Affected

- Hetlioz Lq
- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A) Non-24 hour sleep-wake cycle, initial: documentation of a diagnosis that meets the International Classification of Sleep Disorders diagnostic criteria. Renewal: documentation of an increase in nighttime sleeping and decrease in daytime napping. B) Dyssomnia due to Smith-Magenis syndrome, initial: medical record documentation of the diagnosis. Renewal: documentation of an improvement in sleep quality.
Age Restrictions	Hetlioz LQ only: between 3 years and 15 years of age
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.

HYFTOR

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.

IBTROZI

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.
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.

IMBRUVICA 140MG TABLETS

Products Affected

- Imbruvica TABS 140MG

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, hematologist, or transplant specialist.
Coverage Duration	Lifetime
Other Criteria	1) Documentation why the 140mg capsules cannot be used. 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.

IMKELDI

Products Affected

- Imkeldi

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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, or in certain conditions a hematologist, endocrinologist, neurologist, allergist or dermatologist.
Coverage Duration	Lifetime
Other Criteria	1) Documentation of an inability to swallow oral tablets. 2) Drug must be prescribed for an FDA approved indication, or 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, or 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.

IMPAVIDO

Products Affected

- Impavido

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 leishmaniasis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an infectious disease specialist
Coverage Duration	28 days
Other Criteria	Failure of amphotericin B or Ambisome.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INBRIJA

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: Documentation that the patient's off time has been reduced with Inbrija.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 month. Renewal: Lifetime.
Other Criteria	Initial: failure of maximum tolerable doses of oral levodopa/carbidopa and one of the following: selegiline, ropinirole, pramipexole, entacapone and Ongentys (requires step therapy).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INCRELEX

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.

INFLIXIMAB

Products Affected

- Avsola
- Inflectra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Moderate to severe heart failure, doses greater than 5mg/kg should not be administered
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal: a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 3) Hidradenitis suppurativa (HS) initial: moderate to severe disease evident by documentation of Hurley Stage II or III and at least 3 abscesses or inflammatory nodules. HS renewal: medical record documentation of a reduction in nodules or abscesses. 4) Juvenile idiopathic arthritis (JIA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 5) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 6) Plaque psoriasis (PsO) initial: involvement of more than 3% of body surface area or hand, foot, face, scalp or genital involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning. 7) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 8) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission. 9) Uveitis initial: documentation of non-infectious, intermediate, posterior or panuveitis. Renewal: documentation that treatment response is being monitored for the following development of new inflammatory chorioretinal and/or inflammatory retinal vascular lesions, anterior chamber cell grade or vitreous haze, or visual acuity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for HS and PsO, dermatologist or rheumatologist for PsA, gastroenterologist for UC and CD, ophthalmologist for uveitis, rheumatologist for AS, JIA, JPsA, RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. JIA initial: failure of an 8 week trial of methotrexate. PsO initial: failure of a) one topical agent such

	as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and b) methotrexate or cyclosporine. RA initial: failure of methotrexate and at least one other DMARD such as leflunomide, sulfasalazine, or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive dyskinesia, renewal: medical record documentation of treatment response such as a reduction in the Abnormal Involuntary Movement Scale (AIMS) score from baseline, improvement in involuntary movement, or improvement in functional ability. Chorea associated with Huntington's disease, renewal: medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, or increase in quality of life.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, movement disorder specialist or a psychiatrist.
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.

INREBIC

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 Autoshield Duo 30g X 5mm
- 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

- Atgam
- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamastan
- Gammagard Liquid
- Gammagard Liquid Erc
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Privigen
- Thymoglobulin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) HIV, 2) Allogeneic bone marrow transplant (BMT), 3) Pregnancy-associated idiopathic thrombocytopenic pupura, 4) Myasthenia Gravis (MG), 5) Autoimmune Mucocutaneous Blistering Disease (AMBD), 6) Autoimmune Hemolytic Anemia, Warm Type (AHA-W), 7) Polymyositis and 8) Dermatomyositis
Exclusion Criteria	N/A
Required Medical Information	1) Acute Idiopathic Thrombocytopenic Purpura: platelet less than 30,000 or need to increase platelet prior to major, invasive surgery. 2) Chronic ITP: duration of illness less than 6 months, no concurrent illness/disease explaining thrombocytopenia, platelets persistently below 20,000. 3) ITP in pregnancy: previous deliveries of children with autoimmune thrombocytopenia or platelets below 30,000 associated with bleeding before delivery, or platelets below 75,000 during the current pregnancy or history of splenectomy. 4) Chronic B-Cell Lymphocytic Leukemia with hypogammaglobulinemia: IgG below 600 and evidence of specific antibody deficiency and repeated bacterial infections. 5) HIV: CD4+ greater than 200/mm^3, and clinically symptomatic. 6) BMT: hematologic neoplasm, seropositive for CMV prior to transplant, severe hypogammaglobulinemia defined as IgG less than 400 within the first 100 days post transplant, and seronegative donor. 7) Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) including Guillain-Barre Syndrome: Difficulty with venous access for plasmaphoresis, or rapidly progressive form of disease with symptoms less than 2 weeks or deteriorating ability to ambulate, or deteriorating PFTs. 8) Autoimmune Mucocutaneous Blistering Disease (AMBD): Diagnosis of pemphigus vulgaris, pemphigus foliaceous, bullous pemphigoid, mucous membrane pemphigoid or epidermolysis bullous acquisita. 9) Autoimmune Hemolytic Anemia, Warm Type: Predominance of IgG antibodies or comorbid hepatomegaly or hepatosplenomegaly. 10) Polymyositis and Dermatomyositis: associated with severe disability.11) Acute Myasthenia Gravis (AMG): a) Myasthenic exacerbation defined by difficulty swallowing, acute respiratory failure, or major functional disability or b) presurgical treatment. 12) Multifocal motor neuropathy (For Gammagard only): medical record documentation of treatment response such as improvement in functional ability such as grip strength.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Acute ITP, ITP in pregnancy, HIV, BMT, AMBD, AMG, 3 months: All other diagnoses: Lifetime
Other Criteria	1) For primary immunodeficiencies only, IVIG may be covered in the home under Medicare Part B if coverage guidelines are met. 2) Chronic ITP requires failure of prednisone. 3) AMG requires failure of two of the following: pyridostigmine, prednisone, azathioprine, or methotrexate. 4) AMBD requires a) failure of prednisone and at least one of the following: methotrexate, azathioprine, cyclosporine or cyclophosphamide or b) evidence of rapid disease progression and urgent administration of IVIG is medically necessary. 5) Polymyositis and Dermatomyositis require failure of prednisone and at least one of the following: methotrexate, azathioprine, cyclosporine or cyclophosphamide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IQIRVO

Products Affected

- Iqirvo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Confirmation of a diagnosis of primary biliary cholangitis. 2) documentation of an inadequate treatment response to ursodeoxycholic acid (UDCA), or documented contraindication to UDCA. Renewal: 1) documentation of reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IRON CHELATING AGENTS

Products Affected

- Deferasirox
- 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 (deferiprone and deferasirox) Initial: documentation of elevated sodium ferritin levels. For non-transfusion-dependent thalassemia syndromes (deferasirox only) 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. For transfusional iron overload in patients with sickle cell disease or other anemias (deferiprone only), 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.

ISOTRETINOIN

Products Affected

- Accutane
- 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.

IVABRADINE SOLUTION

Products Affected

- Corlanor SOLN

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. 2) Documentation of an inability to swallow solid dosage forms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JIDEYTRO

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

Products Affected

- Joenja TABS 70MG

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 confirmation of a diagnosis of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS). 2) Weight of at least 45kg or greater.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, hematologist, oncologist, allergist or geneticist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JOURNAVX

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

Products Affected

- Juxtapid CAPS 10MG, 20MG, 2MG, 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

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 criteria: medical record documentation of a diagnosis of cystic fibrosis with genetic confirmation of a mutation in the CFTR gene that is responsive to Kalydeco (ivacaftor). 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.

KERENDIA

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.

KEVEYIS

Products Affected

- Dichlorphenamide

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 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.

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Deficiency of Interleukin-1 Receptor Antagonist (DIRA) renewal: documentation of a positive clinical response, such as low disease activity, or improvement in signs and symptoms. 2) Neonatal onset multi-system inflammatory disease, renewal: improvement in symptoms or laboratory markers. 3) Rheumatoid Arthritis (RA) Renewal: Improved functioning and/or improvement in tender joint count and swollen joint count.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist for RA, rheumatologist, immunologist or geneticist for DIRA.
Coverage Duration	RA Initial: 6 mo. Renewal: 12 mo. Neonatal Onset Multi-system Inflammatory Disease, DIRA: 12 mo.
Other Criteria	RA initial: failure of two of the following: adalimumab, Enbrel, Simponi, Actemra, Orencia, Rinvoq, or Xeljanz (IR or XR). All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KORLYM

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 GRANULE

Products Affected

- Koselugo CPSP

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 or in certain conditions a hematologist, endocrinologist or neurologist. For chronic graft versus host disease, a transplant specialist. For systemic mast cell disease, an allergist or immunologist.
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.

KYGEVVI

Products Affected

- Kygevvi

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 a diagnosis of thymidine kinase 2 deficiency confirmed via genetic testing with variants in the TK2 gene. b) medical record documentation of onset of symptoms prior to 13 years of age. c) Lab results showing AST, ATL and bilirubin within normal limits prior to initiation. Renewal: medical record documentation of clinical benefit from treatment such as slowing of worsening of muscle weakness or maintaining ability to swallow.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic geneticist or neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with the product label
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LAMPIT

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.

LEUPROLIDE

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender dysphoria (GD)
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist, obstetrician/gynecologist, urologist, or endocrinologist.
Coverage Duration	Anemia due to leiomyoma: 3 mo. EM, CPP, uterine leiomyoma: 6 mo. GD: 12 mo. Cancer: Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEVOLEUCOVORIN

Products Affected

- Levoleucovorin INJ 50MG
- Levoleucovorin Calcium

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 oncologist, rheumatologist, or gastroenterologist.
Coverage Duration	12 months
Other Criteria	The following criteria applies to members who newly start on the drug: Medical record documentation of failure of leucovorin or reason why leucovorin cannot be used.
Prerequisite Therapy Required	Criteria DOES 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.

LIRAGLUTIDE

Products Affected

- Liraglutide INJ 6MG/ML

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.

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

Products Affected

- Livdelzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Confirmation of a diagnosis of primary biliary cholangitis. 2) documentation of an inadequate treatment response to ursodeoxycholic acid (UDCA), or documented contraindication to UDCA. Renewal: 1) documentation of reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIVMARLI

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

Products Affected

- Livtencity

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 history of solid organ transplant or hematopoietic stem cell transplantation, and 2) cytomegalovirus infection/disease.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist or oncologist.
Coverage Duration	8 weeks
Other Criteria	Failure of valganciclovir, ganciclovir, cidofovir or foscarnet.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LODOCO

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.

LUCEMYRA

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.

LUMIZYME

Products Affected

- Lumizyme

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) Clinical symptoms and biochemical testing indicates alpha-1,4-glucosidate deficiency, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: 20 mg/kg IV every 2 wk.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPKYNIS

Products Affected

- Lupkynis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Receiving standard therapy including corticosteroids and immunosuppressants. Renewal: medical record documentation of 1) treatment response such as stabilization of eGFR or no worsening of disease activity and 2) continued use of background immunosuppressant therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or rheumatologist
Coverage Duration	12 months
Other Criteria	Failure of Benlysta (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYBALVI

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.

MAVYRET

Products Affected

- Mavyret

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), 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.

MAYZENT

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.

MERCAPTOPURINE SUSPENSION

Products Affected

- Mercaptopurine SUSP

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 dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT 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.

MIPLYFFA

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renewal: documentation of significant improvement in daytime sleepiness and functioning.
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.

MOTEGRITY

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.

MOUNJARO

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

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

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

Products Affected

- Multaq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	NYHA Class IV heart failure. Symptomatic heart failure with recent decompensation requiring hospitalization.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	Lifetime
Other Criteria	Documentation of failure of or intolerance to amiodarone.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: 1) Laboratory test confirming leptin deficiency and 2) Documentation of complications of leptin deficiency such as hyperglycemia, diabetes, hypertriglyceridemia. Renewal criteria: Laboratory test results showing improvement in HbA1c, glucose and triglycerides from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with the FDA approved labeling.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MYCAPSSA

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

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
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 oral contraceptives.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MYQORZO

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 symptomatic 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.

NAGLAZYME

Products Affected

- Naglazyme

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) Diagnostic confirmation of mucopolysaccharidosis VI by lab results such as elevation of glycosaminoglycans (GAG) in the urine or deficiency in galactosamine-4-sulfatase enzyme activity, OR by genetic test confirmation, and 2) Objective, measurable treatment goals. Renewal: Medical record documentation of stabilization of disease progression such as improvement in 12-minute walk test, rate of stair climbing, reduction in urinary GAG levels, or reduction in liver or spleen size.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: 1mg/kg IV once weekly.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NERLYNX

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.

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.

NITYR

Products Affected

- Nityr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary Tyrosinemia type 1 (HT-1) Initial: Medical record documentation of diagnostic confirmation of HT1 including laboratory testing (e.g. the presence of succinylacetone and tyrosyl compounds in urine or elevated plasma concentrations of tyrosine and methionine). Renewal: Improvement in urine succinylacetone (SA), liver function tests, alpha-fetoprotein, and serum tyrosine and phenylalanine levels. For the reduction of urine homogentisic acid (HGA) in adult patients with alkaptonuria (AKU), see criteria for Harliku.
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.

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) For severe asthma with eosinophilic phenotype: Initial criteria: a) Medical record documentation of diagnosis and b) Blood eosinophil levels greater than 150 cells/mcL at baseline or greater than or equal to 300 cells/mcl. Renewal criteria: documentation of or claims history showing a reduction in the use of oral steroids or reduction in asthma symptoms. 2) For eosinophilic granulomatosis with polyangiitis (EGPA): Initial criteria: a) blood eosinophil level of 10% or an absolute count of greater than 1000 cells/mm3, and systemic vasculitis involving two or more extra-pulmonary organs. Renewal criteria: documentation of response to treatment such as achievement of remission, decrease in the use of steroids, decrease in the rate of relapses or improvement in asthma symptoms. 3) For hypereosinophilic syndrome (HES): Initial criteria: Medical record documentation showing that the diagnosis has a duration of at least 6 months, and does not have an identifiable nonhematologic secondary cause. Renewal: documentation of reduction in flares, or other clinical benefit from Nucala. 4) For the treatment of nasal polys: Initial: a) documentation that Nucala is being used as add-on therapy, and b) documentation of an inadequate response to nasal corticosteroids. Renewal: Documentation of clinical benefit from Nucala. 5) For eosinophilic type chronic obstructive pulmonary disease (COPD): initial: a) eosinophil count of at least 300 cells/mcL. Renewal: documentation improvement in COPD, such as a reduction exacerbations or in the use of oral steroids or symptoms.
Age Restrictions	Asthma with eosinophilic phenotype: 6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for asthma, allergist, dermatologist, hematologist or immunologist for HES, allergist, immunologist, pulmonologist, rheumatologist, or vasculitis specialist for EGPA, ENT or otolaryngologist for nasal polyps.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For severe asthma with eosinophilic phenotype: Failure of an inhaled corticosteroid and a long-acting beta agonist.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUEDEXTA

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	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.

NULOJIX

Products Affected

- Nulojix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation that Epstein-Barr virus status is positive.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or transplant specialist.
Coverage Duration	Lifetime
Other Criteria	To prevent or treat an organ transplant rejection, Part B versus D determination will be made to determine coverage. If the drug is to be covered by Part D and the patient is newly started on Nulojix, documentation of failure of tacrolimus and cyclosporine. Nulojix should be used in combination with basiliximab induction, mycophenolate mofetil and corticosteroids.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

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: Medical record documentation of failure of or intolerance to clozapine or reason why clozapine cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Episodic migraine, initial: medical record documentation of 4-14 headache days per month. Episodic migraine, renewal: documentation of treatment response such as a decrease in the number of migraine days, less migraine episodes, decreased abortive medication usage, or emergency room visits related to migraine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Episodic migraine, initial: 6 months. Episodic renewal: 12 months. Acute migraine: lifetime
Other Criteria	1) Episodic migraine prophylaxis, initial and renewal: documentation that Nurtec is not being used with a second CGRP agent for migraine prophylaxis. 2) Acute migraine treatment: 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.

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Used in combination with ursodeoxycholic acid (UDCA) unless there is documentation of intolerance. Renewal: 1) Documentation of a reduction in alkaline phosphatase (ALP) from baseline. 2) Continued use of ursodeoxycholic acid (UDCA) unless there is documentation of intolerance.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist or GI specialist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Initial: Failure to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 months of ursodeoxycholic acid (UDCA), or documented contraindication to UDCA.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OCREVUS

Products Affected

- Ocrevus
- Ocrevus Zunovo

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	12 months
Other Criteria	Documentation that Ocrevus 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.

OMNIPOD

Products Affected

- Omnipod 5 Dexcom G7g6 Intro Kit (gen 5)
- Omnipod 5 Dexcom G7g6 Pods (gen 5)
- Omnipod 5 G7 Intro Kit (gen 5)
- Omnipod 5 G7 Pods (gen 5)
- Omnipod 5 Libre Intro Kit
- Omnipod 5 Libre Pods
- Omnipod Classic Pods (gen 3)
- Omnipod Dash Intro Kit (gen 4)
- Omnipod Dash Pdm Kit (gen 4)
- Omnipod Dash Pods (gen 4)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all: a diagnosis of diabetes. The following criteria apply to those age 21 and older: 1) the member completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen: a) Glycosylated hemoglobin level (HbAlc) greater than 7.0%, b) History of recurring hypoglycemia, c) Wide fluctuations in blood glucose before mealtime, d) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl, or e) History of severe glycemic excursions. OR 2) the member has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.
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.

OPFOLDA

Products Affected

- Opfolda

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 late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) not improving on current enzyme replacement therapy, 2) weight of at least 40kg, and 3) documentation that Opfolda will be used in combination with cipagluosidase alfa-atga.
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.

OPIPZA

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.

OPIUM TINCTURE

Products Affected

- Opium
- Opium Tincture TINC 1%

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	Failure of or contraindication to diphenoxylate/atropine and loperamide.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPSUMIT

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 or New York Heart Association (NYHA) 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.

ORAL IMMUNOTHERAPY

Products Affected

- Grastek
- Odactra
- Ragwitek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Grastek: documentation of a positive skin test or pollen specific IgE antibodies to Timothy grass or cross-reactive grass pollens. For Odactra, 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.

ORAL RIBAVIRIN

Products Affected

- Ribavirin CAPS
- Ribavirin TABS 200MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	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), 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	Ribavirin will be approved consistent with FDA approved labeling or AASLD/IDSA guidelines as part of treatment regimens consisting of ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, and Pegasys if criteria for these drugs are met. For non-formulary drugs such as Sovaldi or Daklinza approved based on the prescriber's supporting statement that all formulary drugs would not be as effective or safe as the non-formulary drug, ribavirin will be approved as requested consistent with FDA approved labeling or AASLD/IDSA guidelines.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORAL TRANSMUCOSAL FENTANYL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Not approved for use of acute or postoperative pain and for opioid non-tolerant patients.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, palliative care prescriber, or pain specialist.
Coverage Duration	12 months
Other Criteria	Documentation of 1) Failure of two short-acting opioids (eg, oxycodone, morphine sulfate, etc) or an inability to swallow, dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting AND 2) Patient is on or will be on a long-acting narcotic (eg, methadone, morphine sulfate ER, oxycodone ER, fentanyl), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENCIA

Products Affected

- Orencia
- Orencia Clickject

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 improvement in tender joint count and swollen joint count. 2) Psoriatic Arthritis (PsA) Renewal: Improved functioning and/or decreased in the number of tender, swollen joints and reduction in skin lesions and/or has disease stability. 3) Prophylaxis of acute graft versus host disease (aGVHD): a) documentation that Orencia will be used with a calcineurin inhibitor and methotrexate, and b) documentation that the patient will be undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated-donor. 4) Rheumatoid arthritis (RA) renewal: Improved functioning and/or improvement in tender joint count and swollen joint count.
Age Restrictions	JIA: 6 years of age or older for Orencia IV and 2 years of age or older for Orencia subcutaneous injection
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, hematologist, oncologist or transplant specialist for aGVHD, rheumatologist for JIA, RA.
Coverage Duration	aGVHD: 28 days. All other indications: Initial: 6 months. Renewal: 12 months.
Other Criteria	JIA 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.

ORENITRAM

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Documentation of WHO Group 1 pulmonary arterial hypertension diagnosed by right heart catheterization. 2) Documentation of New York Heart Association (NYHA) Class III to IV. Renewal: Documentation of clinical improvement or disease stability such as increased exercise capacity, improvement in WHO functional class or decreased clinical worsening events.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 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.

ORFADIN

Products Affected

- Nitisinone
- Orfadin SUSP

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 diagnostic confirmation of HT1 including laboratory testing (e.g. the presence of succinylacetone and tyrosyl compounds in urine or elevated plasma concentrations of tyrosine and methionine). Renewal: Improvement in urine succinylacetone (SA), liver function tests, alpha-fetoprotein, and serum tyrosine and phenylalanine levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: initial 1 mg/kg/day (divided into 2 doses) titrated to achieve suppression of SA, maximum 2 mg/kg/day. For Orfadin Suspension: Documentation of an inability to swallow solid dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORGOVYX

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

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

Products Affected

- Orilissa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ob/gyn specialist.
Coverage Duration	EM: 24 months. EM with dyspareunia: 6 months. EM with moderate hepatic impairment: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORKAMBI

Products Affected

- Orkambi

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 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	For Orkambi Pack (Suspension): documentation of an inability to swallow solid dosage forms.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OSENVELT

Products Affected

- Osenvelt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Preexisting hypocalcemia and 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.

OTEZLA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Bechet's syndrome (BS) initial: medical record documentation of oral ulcer's caused by Bechet's syndrome. BS renewal: medical record documentation of reduction in severity of oral ulcers or improvement in symptoms. 3) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: documentation of baseline BSA involvement. PsO renewal: improvement in affected BSA, plaque severity and/or functioning.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA or BS.
Coverage Duration	Initial: 6 months. Renewal: 12 months
Other Criteria	Mild PsO initial: failure of 1) one topical corticosteroid (i.e. betamethasone or clobetasol), and 2) one of the following: calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization). Moderate to severe PsO initial: failure of 1) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization) and 2) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OVERACTIVE BLADDER DRUGS

Products Affected

- Oxybutynin Chloride SOLN
- Oxybutynin Chloride TABS 5MG
- Oxybutynin Chloride Er
- Solifenacin Succinate
- Tolterodine Tartrate
- Tolterodine Tartrate Er
- 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 applies to members age 60 and older: medical record documentation of failure of a) Myrbetriq and b) Gemtesa (also requires step therapy with Myrbetriq).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OXERVATE

Products Affected

- Oxervate

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 neurotrophic keratitis.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	8 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OXYCODONE EXTENDED RELEASE

Products Affected

- Oxycodone Hydrochloride Er T12A 10MG, 20MG, 40MG
- 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

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.

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.

PALYNZIQ

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

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.

PARENTERAL BISPHOSPHONATES

Products Affected

- Pamidronate Disodium INJ 30MG/10ML, 6MG/ML, 90MG/10ML
- Zoledronic Acid INJ 4MG/100ML, 4MG/5ML, 5MG/100ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy: albumin-corrected serum calcium above 12mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	1) For the diagnosis of osteoporosis: failure of two oral bisphosphonates such as ibandronate and alendronate or reason why bisphosphonates cannot be used. Risedronate is available after failure of ibandronate and alendronate. 2) For end stage renal disease (ESRD) patients on dialysis, 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.

PARICALCITOL

Products Affected

- Paricalcitol

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	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 1) An inability to take solid oral dosage forms and 2) Failure of or contraindication to sertraline solution.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PEGASYS

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) For the treatment of hepatitis B (HBV): a) Compensated cirrhosis and HBV DNA greater than 2000 IU/ml or b) If HBeAg positive, HBV DNA at least 20,000 IU/ml and serum ALT is persistently elevated after 3-6 months or liver biopsy shows at least moderate inflammation or significant fibrosis or c) If HBeAg negative, HBV DNA greater than 2000 IU/ml and serum ALT is persistently elevated after 3-6 months or liver biopsy shows at least moderate inflammation or fibrosis. 2) For the treatment of hepatitis C (HCV): Detectable HCV RNA (viral load), 2) Documentation of treatment history including response to previous treatment (treatment naive, previous relapser, partial responder or null responder), and 3) Documentation of presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, Hepatitis C specialist or hepatologist.
Coverage Duration	HBV 12 mo. HCV: 48 weeks
Other Criteria	For the treatment of Hepatitis C, pegylated interferon is no longer standard of care. Refer to criteria for Mavyret, sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, and Vosevi.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PENBRAYA

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

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.

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.

PERAMPANEL

Products Affected

- Perampanel TABS

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.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PERAMPANEL SUSPENSION

Products Affected

- Perampanel SUSP

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. 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.

PLERIXAFOR

Products Affected

- Plerixafor

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 oncologist or hematologist.
Coverage Duration	4 days
Other Criteria	Use in combination with a granulocyte colony stimulating factor.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POSACONAZOLE

Products Affected

- Noxafil PACK
- Posaconazole
- 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 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 or itraconazole. 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.

POTASSIUM BINDERS

Products Affected

- Lokelma
- Veltassa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: medical lab documentation of hyperkalemia. Renewal criteria: reduction in serum potassium from baseline.
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.

PRALUENT

Products Affected

- Praluent

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 reducing the risk of major adverse cardiovascular (CV) events for patients with established atherosclerotic cardiovascular disease (ASCVD), or for patients that are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. 2) For treatment of hypercholesterolemia or primary heterozygous familial hypercholesterolemia (HeFH): a) in patients with established ASCVD, or who are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. b) in patients without ASCVD and who are at a low risk for major adverse CV events: LDL-C of 70mg/dL or greater. 3) Homozygous familial hypercholesterolemia (HoFH): diagnosis confirmed by genetic testing, or by documentation of either a) untreated LDL-C greater than 500 mg/dL, or b) treated LDL-C greater than 300 mg/dL, AND i) xanthoma before 20 years of age or ii) evidence of heterozygous familial hypercholesterolemia in both parents. Renewal criteria for all indications: documentation of LDL reduction from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	For all indications: Medical record documentation of failure of, documented contraindications, or intolerance or significant side effects on one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PRENATAL VITAMINS

Products Affected

- Pnv Prenatal Plus Multivitamin + Dha
- 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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Drug-sensitive tuberculosis, latent infection due to Mycobacterium tuberculosis, extra-pulmonary infection due to Mycobacterium tuberculosis, or MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy.
Required Medical Information	Medical record documentation of 1) Extensively drug resistant pulmonary tuberculosis confirmed by culture and drug sensitivity, 2) Pretomanid will be used in combination with Sirturo and linezolid.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease or tuberculosis (TB) specialist.
Coverage Duration	26 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PREVYMIS

Products Affected

- Prevymis INJ
- 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.

PULMONARY FIBROSIS AGENTS

Products Affected

- Nintedanib Esylate
- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A) Idiopathic pulmonary fibrosis, initial criteria: medical record documentation of the diagnosis of idiopathic pulmonary fibrosis based on the presence of a usual interstitial pneumonia pattern on high-resolution computed tomography or surgical lung biopsy. B) Systemic sclerosis-associated interstitial lung disease, initial: medical record documentation of systemic sclerosis-associated interstitial lung disease. Renewal criteria (all diagnoses): medical record documentation of a decrease in the decline in force vital capacity (FVC).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PYRUKYND

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

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.

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

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

Products Affected

- Redemplo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Familial Chylomicronemia Syndrome (FCS), initial: confirmation of a diagnosis of Familial Chylomicronemia Syndrome (FCS) with both of the following: 1) lab test results showing fasting TG levels greater than or equal to 880 mg/dL and 2) genetic test results confirming FCS, OR one of the following: history of pancreatitis, eruptive xanthomas, hepatosplenomegaly, hepatosteatosis, or lipemia retinalis. FCS, Renewal: 1) Lab results showing a reduction in triglycerides from baseline, and 2) documentation of clinical improvement such as: a reduction in episodes of acute pancreatitis, or lack of worsening of hepatosplenomegaly, hepatosteatosis, and lipemia retinalis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, lipid specialist, or pancreatologist
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.

RELISTOR

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

Products Affected

- Repatha
- Repatha Sureclick

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 reducing the risk of major adverse cardiovascular (CV) events for patients with established atherosclerotic cardiovascular disease (ASCVD), or for patients that are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. 2) For treatment of hypercholesterolemia or primary heterozygous familial hypercholesterolemia (HeFH): a) in patients with established ASCVD, or who are at an intermediate or high risk (at least 7.5%) for major adverse CV events: LDL-C of 55mg/dL or greater. b) in patients without ASCVD and who are at a low risk for major adverse CV events: LDL-C of 70mg/dL or greater. 3) Homozygous familial hypercholesterolemia (HoFH): diagnosis confirmed by genetic testing, or by documentation of either a) untreated LDL-C greater than 500 mg/dL, or b) treated LDL-C greater than 300 mg/dL, AND i) xanthoma before 20 years of age or ii) evidence of heterozygous familial hypercholesterolemia in both parents. Renewal criteria for all indications: documentation of LDL reduction from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist or lipid specialist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	For all indications: Medical record documentation of failure of, documented contraindications, or intolerance or significant side effects on one high-intensity statin therapy such as atorvastatin 40mg-80mg or rosuvastatin 20mg-40mg for 12 weeks. Contraindications and significant side effects to statins include evidence of rhabdomyolysis or persistent myalgia or myositis.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REVCOVI

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.

REYVOW

Products Affected

- Reyvow

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.

REZDIFFRA

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.

REZUROCK

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

Products Affected

- Rinvoq
- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) initial: inadequate response or intolerance to a TNF inhibitor. AS Renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis initial (nr-axSpA): inadequate response or intolerance to a TNF inhibitor. nr-axSpA renewal: improved functioning and/or improvement in signs and symptoms of nr-axSpA. 3) Atopic dermatitis (AD) initial: body surface are involvement of at least 10% at baseline. AD renewal: medical record documentation of a positive treatment response such as a reduction in body surface area involvement, improvement in itching, or improvement in functional ability, reduction in the Investigator Global Assessment or Eczema Area and Severity Index from baseline. 4) Crohn's disease (CD) and ulcerative colitis (UC): initial: a) moderate to severe disease activity, and b) inadequate response or intolerance a TNF inhibitor OR if treatment is inadvisable (ie, CI) with a TNF-I, pt has had a trial of a systemic therapy approved for CD/UC (eg, risankizumab, ustekinumab). CD and UC renewal: medical record documentation of treatment response such as decrease in symptoms or clinical remission. 5) Polyarticular juvenile idiopathic arthritis (pJIA): initial: inadequate response or intolerance to a TNF inhibitor such as adalimumab. pJIA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 6) Psoriatic arthritis (PsA) initial: inadequate response or intolerance to a TNF inhibitor. PsA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 7) Rheumatoid arthritis (RA) initial: inadequate response or intolerance to a TNF inhibitor. RA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 8) Giant cell arteritis (GCA), renewal: clinical remission or a reduction in signs and symptoms from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: allergist, dermatologist or immunologist for AD, dermatologist or rheumatologist for PsA, gastroenterologist for UC and CD, rheumatologist for AS, nr-axSpA, pJIA, RA.

Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AD initial: Failure of or contraindication to a) one of the following very high potency topical steroids: augmented betamethasone, clobetasol or halobetasol and b) tacrolimus ointment. AS and nr-axSpA, initial: failure of one non-steroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. 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.

RIOCIGUAT

Products Affected

- Adempas
- Riociguat

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.

RITUXIMAB

Products Affected

- Riabni
- Rituxan
- Ruxience
- Truxima

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) renewal: medical record documentation of a 20% or greater improvement in tender joint count and swollen joint count or a reduction in specific, objective pain symptoms and/or improved functioning.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, rheumatologist or dermatologist.
Coverage Duration	NHL, CLL, WG, MPA and pemphigus vulgaris: Lifetime. RA Initial: 6 months. RA Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT 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

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.

ROZLYTREK PELLET

Products Affected

- Rozlytrek PACK

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.

RSV VACCINE

Products Affected

- Arexvy

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 age 50 years of age or older.
Age Restrictions	50 years of age and older
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.

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.

RYBELSUS

Products Affected

- Rybelsus TABS 14MG, 3MG, 7MG

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.

RYTARY

Products Affected

- Rytary

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 movement disorder specialist.
Coverage Duration	Lifetime
Other Criteria	Failure of carbidopa/levodopa ER tablets.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SANDOSTATIN LAR

Products Affected

- Octreotide Acetate INJ 10MG, 20MG, 30MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) For the treatment of acromegaly: a) Initial: medical record documentation of failure of surgery, radiation or bromocriptine or reason or reason why surgery, radiation or bromocriptine are not options. b) Renewal: documentation of IGF-1 normalization or symptom improvement. 2) Renewal criteria for all other conditions: reduction in symptoms such as stool frequency.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of acromegaly, metastatic carcinoid tumors and vasoactive intestinal peptide tumors: documentation of response to and tolerance to octreotide immediate release injection.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SAPHNELO

Products Affected

- Saphnelo INJ 300MG/2ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe active CNS lupus or used in combination with IV cyclophosphamide
Required Medical Information	Initial criteria: 1) Medical record documentation of a diagnosis of systemic lupus erythematosus (SLE) and is auto-antibody positive as defined as Antinuclear antibody (ANA titer) greater than or equal to 1:80 or anti-double stranded DNA antibody (Anti-dsDNA) greater than or equal to 30 IU/ml. 2) Receiving standard therapy including NSAIDs, antimalarials, corticosteroids or immunosuppressants. Renewal criteria: medical record documentation of treatment response such as an improvement in the SELENA-SLEDAI score or no worsening of disease activity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist.
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.

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.

SAVELLA

Products Affected

- Milnacipran Hydrochloride
- Milnacipran Hydrochloride Titration Pack
- Savella
- Savella Titration 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 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.

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

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

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

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

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent therapy with nitrates.
Required Medical Information	Documentation of New York Heart Association (NYHA) 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	For oral suspension: documentation of a reason why sildenafil tablets cannot be used such as failure, inability to swallow oral dosage form, or contraindication that is also not a contraindication to the suspension.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIMPONI

Products Affected

- Simponi
- Simponi Aria

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS.2) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Rheumatoid arthritis (RA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, gastroenterologist for UC, rheumatologist for AS and RA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS initial: failure of one oral nonsteroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. RA initial: failure of methotrexate, leflunomide, sulfasalazine, or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIRTURO

Products Affected

- Sirturo

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) multi-drug resistant pulmonary tuberculosis confirmed by culture and drug sensitivity and must be resistant to at least isoniazid and rifampin.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease or tuberculosis (TB) specialist.
Coverage Duration	24 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYCLARYS

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

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Crohn's disease (CD) initial: moderate to severe disease activity. CD renewal criteria: decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Psoriatic arthritis (PsA) renewal: improved functioning and/or greater improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning. 4) Ulcerative colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	PsO initial: failure of a) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment or tazarotene (requires prior authorization), and b) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SODIUM PHENYLBUTYRATE

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use as emergency treatment of acute hyperammonemia.
Required Medical Information	Initial: Medical record documentation of diagnostic confirmation by plasma quantitive amnio acid analysis or urinary orotic acid testing or enzyme activity from a liver biopsy or genetic testing. Renewal: Medical record documentation of stabilization of disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Dosing consistent with product label: Usual total daily dose is 450-600mg/kg/day in patients weighing less than 20kg, or 9.9-13.0 G/m2/day in larger patients. Maximum dose is 20 G/day.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOFOSBUVIR/VELPATASVIR

Products Affected

- Epclusa PACK
- Epclusa TABS 200MG; 50MG
- Sofosbuvir/velpatasvir

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), 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	Criteria will be applied consistent with current AASLD/IDSA guidance.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOHONOS

Products Affected

- Sohonos

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.

SOLTAMOX

Products Affected

- Soltamox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concomitant coumarin-type anticoagulant therapy or in women with a history of deep vein thrombosis or pulmonary embolus.
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.

SOMATROPINS

Products Affected

- Genotropin
- Genotropin Miniquick
- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Omnitrope
- Zorbtive

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Short bowel syndrome
Exclusion Criteria	1) In patients with Prader-Willi syndrome, patients who are severely obese, have a history of upper airway obstruction, sleep apnea or severe respiratory impairment. 2) Not approved for the treatment of acute critical illness, respiratory failure or patients with an underlying intracranial tumor.
Required Medical Information	1) Growth Hormone Deficiency (GHD): a) short stature (SS) defined by one of the following:(i) height more than 3 standard deviations (SD) below mean for age and gender or (ii) height below the 3rd percentile for age and gender or (iii) height more than 2 SD below mean and growth velocity (GV) below the 25th percentile for age and gender or (iv) growth velocity less than 2 SD below the mean for age and gender AND b) laboratory results consistent with growth hormone deficiency. 2) Idiopathic SS: short stature as defined under GHD. 3) Prader-Willi syndrome: confirmed by genetic testing or decreased muscle tone by exam. 4) Turner's Syndrome and short-stature homeobox-containing gene (SHOX) deficiency: confirmation of diagnosis by genetic testing. 5) Small for gestational age (SGA) with no catch-up growth by age 2 to 4 years: height remains less than 2 SD below the mean for age and gender. 6) Adult-Onset GHD: a) Pituitary, hypothalamic disease, or GHD as a result of tumor, irradiation, surgery or trauma AND b) laboratory results consistent with growth hormone deficiency. 7) Childhood-Onset Adult GHD: a) laboratory results consistent with growth hormone deficiency. Renewal for all: documentation of improved quality of life or clinical benefit.
Age Restrictions	Short bowel syndrome (SBS): 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, gastroenterologist, or nephrologist.
Coverage Duration	SBS: 4 weeks. All other diagnoses: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOMATULINE DEPOT

Products Affected

- Lanreotide Acetate
- Somatuline Depot INJ 60MG/0.2ML, 90MG/0.3ML

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	1) For the treatment of acromegaly and Carcinoid Syndrome: failure of octreotide or reason why octreotide cannot be used. 2) The following criteria applies to members who newly start on the drug for gastroenteropancreatic neuroendocrine tumors: failure of octreotide or reason why octreotide cannot be used.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Baseline liver function tests are not greater than 3 times the upper limit of normal.
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.

SOTYLIZE

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.

SPRAVATO

Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

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 treatment resistant major depressive disorder: medical record documentation of failure of separate 6 week trials of two different antidepressants . 2) For treatment of depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior: documentation that Spravato will be used in conjunction with an oral antidepressant.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SPRITAM

Products Affected

- Levetiracetam TB3D
- Spritam

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.

STAMARIL

Products Affected

- Stamaril

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 planned travel to a country at risk for yellow fever. Renewal: Documentation that it has been at least 10 years since the previous dose, or that a booster is recommended to travel to a specific country.
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.

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis confirmed by genetic testing, low serum activity of alkaline phosphatase or elevated pyridoxine.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, geneticist or metabolic specialist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUCRAID

Products Affected

- Sucraid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Diagnosis confirmed by one of the following: a) acidic stool pH less than 6, b) increase in breath hydrogen of greater than 10 ppm when challenged with sucrose or c) genetic testing showing sucrase deficiency and 2) Objective, measurable treatment goals are provided. Renewal: medical record documentation of treatment response such as improvement in growth and development or decrease in diarrhea, flatulence or abdominal pain.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, gastroenterologist or metabolic specialist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: Weight greater than 15kg: 17,000 IU per meal or snack. Weight less than 15kg: 8,500 IU per meal or snack.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYMDEKO

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

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

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

Products Affected

- Synarel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (EM): requires laparoscopic confirmation of diagnosis.
Age Restrictions	Central precocious puberty: for females, 11 years of age or younger. For males males age 12 years of age or younger. Endometriosis: 18 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with: endocrinologist for CPP, ob/gyn for EM.
Coverage Duration	Endometriosis: 6 months. Central precocious puberty: until age 11 for females and age 12 for males.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYSTEMIC TESTOSTERONE

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.

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.

TAKHZYRO

Products Affected

- Takhzyro

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 criteria for long term prevention: Documentation of a reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks or clinical documentation of functional improvement.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, allergist or immunologist.
Coverage Duration	Long term prevention, initial: 6 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TALTZ

Products Affected

- Taltz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) renewal: improved functioning and/or signs and symptoms of AS. 2) Active non-radiographic axial spondyloarthritis (nr-axSpA) renewal: improved functioning and/or signs and symptoms of active nr-axSpA. 3) Psoriatic arthritis renewal: improvement in functioning and/or decreased in number of tender, swollen joints and reduction in skin lesions and/or has disease stability. 4) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, rheumatologist for AS, nr-axSpA.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	AS initial: failure of two of the following: adalimumab, Enbrel, Simponi, Cosentyx, Rinvoq, or Xeljanz. All require prior authorization. Nr-axSPA initial: failure of two of the following: adalimumab, Cosentyx, Rinvoq. All require prior authorization. PsA initial: failure of two of the following: adalimumab, Enbrel, Simponi, Orencia, Otezla, Cosentyx, Skyrizi, ustekinumab, Rinvoq, or Xeljanz (IR or XR). All require prior authorization. PsO initial: failure of two of the following: adalimumab, ustekinumab, Enbrel, Otezla, Cosentyx, or Skyrizi. All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TARPEYO

Products Affected

- Tarpeyo

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 primary immunoglobulin A nephropathy at risk of rapid disease progression.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	9 months
Other Criteria	Failure of or intolerance to prednisone.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAVALISSE

Products Affected

- Tavalisse

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 platelet count less than 20,000 per mm3 or less than 30,000 per mm3 with symptoms of bleeding. Renewal criteria: Medical record documentation of) maintenance of platelet counts of at least 30,000 per mm3 or an increase in platelet counts from baseline with resolution of bleeding episodes.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months
Other Criteria	For chronic immune (idiopathic) thrombocytopenia: documentation of an insufficient response to a previous treatment such as: steroids, IVIG, Promacta, or Rituxan.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: documentation of microscopic polyangiitis or granulomatosis with polyangiitis, a positive test for anti-PR3 or anti-MPO, documentation that Tavneos will be used in combination with standard therapy (including corticosteroids), and at least 1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria on the Birmingham Vasculitis Activity Score (BVAS). Renewal: Documentation of clinical remission, improved BVAS score or improved functioning and/or symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist 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.

TAZORAC

Products Affected

- Tazarotene CREA 0.1%
- 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	12 months
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.

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial criteria: Transthyretin variant by genotyping, documented amyloid deposit by biopsy. Renewal criteria: medical record documentation of improvement in pain or functioning.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
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.

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	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients at increased baseline risk for osteosarcoma (including those with Paget's disease of bone, open epiphyses, or prior external beam or implant radiation therapy involving the skeleton).
Required Medical Information	1) Postmenopausal female with either a) evidence of recent radiographic osteoporotic fracture while on a bisphosphonate or b) high risk or very high risk of osteoporotic fracture. 2) Male with primary or hypogonadal osteoporosis and either a) evidence of history of osteoporotic fracture or b) multiple risk factors for osteoporotic fractures such as BMD less than -2.5 SD, low BMI, history of hip fracture in 1st degree relative, tall stature, and chronic daily use of tobacco. 3) Female or male with steroid-induced osteoporosis and both: a) steroid use for greater than 3 months at a dose of 5mg per day prednisone (or equivalent) and b) BMD T-score less than -2.5. Renewal for all indications: for use longer than 2 years, documentation of high risk of fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of or contraindication to an oral bisphosphonate, unless considered very high risk for fracture.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	1) Tardive dyskinesia and 2) Tourette's Syndrome.
Exclusion Criteria	1) Patients who are actively suicidal or with untreated or inadequately treated depression. 2) Patients with impaired hepatic function. 3) Patients taking monoamine oxidase inhibitors. 4) Patients taking reserpine. At least 20 days should elapse after stopping reserpine before starting tetrabenazine.
Required Medical Information	Initial criteria: If the request is for doses greater than 50 mg per day, medical record documentation of CYP2D6 genotyping is required. Renewal criteria: Medical record documentation of a clinical response such as improvement in chorea, ability to perform activities of daily living, reduction in falls, and increase 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.

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Erythema Nodosum Leprosum (ENL) Renewal criteria: documentation of response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: hematologist or oncologist for MM, dermatologist for ENL, infectious disease specialist for infection.
Coverage Duration	Cancer: Lifetime. All others: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TICOVAC

Products Affected

- Ticovac

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 planned travel to an endemic country. Renewal for fourth dose: documentation of continued risk after 3 years from initial doses.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 12 months. Renewal: 1 month.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TIGECYCLINE

Products Affected

- Tigecycline

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Complicated infection of skin and/or subcutaneous tissue: Culture and sensitivity indicates resistance to vancomycin plus aztreonam. 2) Complicated infectious disease of abdomen: Culture and sensitivity indicates resistance to imipenem/cilastin. 3) Community acquired pneumonia: a) Severity of infection necessitates IV treatment and a) Culture and sensitivity indicates resistance to i) a beta-lactam, such as cefotaxime, ceftriaxone plus azithromycin or clarithromycin and ii) fluoroquinolone such as levofloxacin or moxifloxacin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TIROSINT 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.

TOCILIZUMAB

Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen
- Avtozma

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.

TOLVAPTAN

Products Affected

- Tolvaptan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Autosomal dominant polycystic kidney disease, initial: evidence of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD), defined by either a confirmed glomerular filtration rate (GFR) decline of at least 3 mL/min per year over 1 year and/or 2.5 mL/min per year over a period of 5 years OR a total kidney volume increase of at least 5% per year confirmed by at least 3 repeated ultrasound or MRI measurements taken at least 6 months apart.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Lifetime
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOPICAL ANTIVIRALS

Products Affected

- Acyclovir CREA
- Acyclovir OINT
- 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	1) 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. 2) For penciclovir: 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.

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.

TOPIRAMATE 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.

TREMFYA

Products Affected

- Tremfya
- Tremfya Induction Pack For Crohns Disease/ulcerative Colitis
- Tremfya Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Crohn's Disease (CD) initial: moderate to severe disease activity. CD renewal: medical record documentation of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Psoriasis with arthropathy (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning. 4) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, and/or clinical remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Plaque psoriasis, initial criteria: failure of a) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization) and b) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TREPROSTINIL

Products Affected

- Treprostinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of New York Heart Association (NYHA) Class II to IV.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
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.

TRIKAFTA

Products Affected

- Trikafta

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 with at least one variant in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is either responsive based on clinical and/or in vitro data or results in production of CFTR protein. 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.

TRINTELLIX

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.

TRULICITY

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

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.

TRYNGOLZA

Products Affected

- Tryngolza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Familial Chylomicronemia Syndrome (FCS) initial: 1) Documentation of a diagnosis of Familial Chylomicronemia Syndrome confirmed by a genetic test. Renewal: 1) a reduction in triglycerides from baseline, and 2) documentation of clinical improvement such as episodes of acute pancreatitis. Severe hypertriglyceridemia (sHTG), initial: persistent TG ≥500 mg/dL despite lifestyle modification and standard therapy such as statins, fibric acid derivatives, or prescription omega-3 fatty acids. Renewal: a reduction in triglycerides from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a lipid specialist, endocrinologist, cardiologist, gastroenterologist, or pancreatologist.
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.

TRYVIO

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.

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, or prior external beam or implant radiation therapy involving the skeleton).
Required Medical Information	1) For Postmenopausal females: a) evidence of recent radiographic osteoporotic fracture while on a bisphosphonate or b) high risk or very high risk of osteoporotic fracture. 2) For males: a) documentation of high risk of fracture or b) failure of or intolerance to other osteoporosis therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months. Use is not recommended for longer.
Other Criteria	1) Failure of or contraindication to an oral bisphosphonate, unless considered very high risk for fracture. 2) If there is prior history of a parathyroid hormone analog, cumulative use is not greater than 2 years. If there is prior history then coverage will be allowed to provide a maximum of 24 months of treatment during a lifetime.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of or existing progressive multifocal leukoencephalopathy.
Required Medical Information	Crohn's disease: 1) Baseline CRP greater than 2.87ml/L and 2) if the patient is currently on oral corticosteroids, requires documentation of a steroid taper plan. Renewal criteria for Crohn's disease: documentation of a) reduction in CDAI or number of disease flares and/or improved quality of life, b) If previously on oral steroids, steroid has been successfully discontinued, and c) no history of serious infection or evidence of liver toxicity since the previous authorization. MS renewal: documented benefit since initiation of Tysabri such as delay in the accumulation of physical disability and/or reduction in the frequency of clinical exacerbations and no symptoms suggestive of PML (e.g. progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, and changes in thinking, memory, and orientation leading to confusion and personality changes).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with: gastroenterologist for CD, neurologist for MS.
Coverage Duration	12 months
Other Criteria	1) Crohn's disease: failure of infliximab and adalimumab. 2) Multiple sclerosis: failure of interferon-beta (Avonex, Rebif, Betaseron), glatiriamer, fingolimod or dimethyl fumarate with documentation of all of the following a) continuation of clinical relapses b) CNS lesion progression on MRI or worsening disability and c) documentation that Tysabri is being requested for monotherapy and is not intended to be used in combination with other multiple sclerosis agents.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UBRELVY

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

Products Affected

- Stelara
- Steqeyma
- Ustekinumab
- Yesintek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Crohn's Disease (CD) initial: moderate to severe disease activity. CD renewal: medical record documentation of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. 2) Psoriasis with arthropathy (PsA) renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 3) Plaque psoriasis (PsO) initial: involvement of at least 3% of body surface area or hand, foot, face, scalp, or genital involvement. PsO renewal: improvement in affected body surface area, plaque severity and/or functioning. 4) Ulcerative Colitis (UC) initial: moderate to severe disease activity. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, and/or clinical remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist for PsO, dermatologist or rheumatologist for PsA, gastroenterologist for CD and UC.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For Stelara only: reason why Yesintek and Steqeyma cannot be used. 1) Plaque psoriasis, initial criteria: failure of a) one topical agent such as a corticosteroid (i.e. betamethasone or clobetasol), calcipotriene, tacrolimus ointment, or tazarotene (requires prior authorization) and b) methotrexate or cyclosporine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UZEDY

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.

VANRAFIA

Products Affected

- Vanrafia

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 primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN, b) urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g and c) maximally tolerated dose of a renin-angiotensin system inhibitor (ACE or ARB). Renewal: medical record documentation of a decrease in urine protein-to-creatinine ratio from baseline.
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 require use of a prerequisite Part D drug.

VARIZIG

Products Affected

- Varizig INJ 125UNIT/1.2ML

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	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VAXCHORA

Products Affected

- Vaxchora

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 plan to travel to a cholera-affected area.
Age Restrictions	Between 2 years and 64 years of age
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.

VEOZAH

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.

VEPPANU

Products Affected

- Veppanu

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	For new starts only: Failure of or contraindication to Orserdu or Inluriyo. For all: 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.

VERKAZIA

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

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

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.

VESICARE LS

Products Affected

- Vesicare Ls

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 neurogenic detrusor overactivity.
Age Restrictions	N/A
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.

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic drinks daily. 2) Known or suspected biliary duct obstruction. 3) History of or current chronic or severe constipation. 4) Severe hepatic impairment. 5) Known or suspected mechanical gastrointestinal obstruction. 6) History of pancreatitis. 7) Sphincter of Oddi disease or dysfunction. 8) Structural disease of the pancreas such as pancreatic duct obstruction.
Required Medical Information	Initial: Medical record documentation of irritable bowel syndrome with diarrhea. Documented symptoms of loose or watery stools at least greater than or equal to 25% of stools. Renewal: Medical record documentation of a significant reduction in diarrhea frequency and abdominal pain and/or improvement in quality of life during the 12 week trial.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Renewal: Lifetime.
Other Criteria	Failure of loperamide and dicyclomine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIGABATRIN

Products Affected

- Vigabatrin
- Vigafyde
- Vigpoder

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.

VIIBRYD

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.

VIJOICE

Products Affected

- Vijoice

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 a mutation in the PIK3CA gene. b) documentation of the need for systemic therapy. Renewal: documentation of a reduction in lesion size or significant improvement in symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a genetic specialist.
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.

VOQUEZNA PAK

Products Affected

- Voquezna Dual Pak
- Voquezna Triple Pak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Confirmation of active helicobacter pylori infection via diagnostic testing such as biopsy, urea breath test, or stool antigen assay.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	14 days
Other Criteria	Documentation of failure of or high likelihood of resistance to a) rifabutin triple therapy (rifabutin, amoxicillin and a proton pump inhibitor) or b) bismuth quadruple therapy (bismuth salicylate, metronidazole, tetracycline and a proton pump inhibitor).
Prerequisite Therapy Required	Criteria DOES 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

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

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 withing 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

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

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

Products Affected

- Voyxact

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN) initial: a) biopsy results confirming IgAN, b) laboratory results confirming proteinuria, and c) on maximally tolerated dose of a renin-angiotensin system inhibitor (ACE or ARB), unless there is intolerance or contraindication. IgAN Renewal: medical record documentation of clinical benefit, such as a decrease in urine protein-to-creatinine ratio from baseline.
Age Restrictions	18 years of age or older
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 require use of a prerequisite Part D drug.

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: 1) Diagnosis confirmed by one of the following: a) biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity, b) genotyping revealing 2 pathogenic mutations of the glucocerebrosidase gene. 2) Severity of disease results in one or more of the following conditions: a) moderate to severe anemia, b) thrombocytopenia with bleeding tendency, c) bone disease, d) significant hepatomegaly or splenomegaly. 3) Objective, measurable treatment goals are provided. Renewal: 1) Medical record documentation of stabilization of disease progression, such as a) improvement in hematologic markers, such as increased hgb/hct and/or platelet counts, b) reduction in spleen or liver volume, c) reduction in biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), d) reduction in skeletal markers, such as DEXA scan, bone pain, bone age (for patient age 14 years or less).
Age Restrictions	4 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Dosing consistent with product label: 60 units/kg every other week. Range 15-60 units/kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYNDAQEL

Products Affected

- Vyndamax
- Vyndaqel

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

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Generalized myasthenia gravis (gMG): Renewal, medical record documentation of a clinical response to Vyvgart Hytrulo, such as improvement in functioning. 2) Chronic inflammatory demyelinating polyneuropathy (CIDP): medical record confirmation of a diagnosis of CIDP. Renewal: medical record documentation of a clinical response to Vyvgart Hytrulo, such as improvement from baseline strength or weakness.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	1) gMG, initial: failure of a) an oral immunosuppressant such as azathioprine, mycophenolate, cyclosporine or tacrolimus, and b) intravenous immune globulin. 2) CIDP, initial: failure of intravenous immune globulin.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WAINUA

Products Affected

- Wainua

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 genetic mutation in the TTR gene and Stage 1 or 2 familial amyloid polyneuropathy (FAP). Renewal: documentation of improvement in pain or functioning.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
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.

WAKIX

Products Affected

- Wakix

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	Prescribed by or in consultation with a sleep medicine specialist or neurologist.
Coverage Duration	Initial: 6 months. Renewal: Lifetime.
Other Criteria	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WAYRILZ

Products Affected

- Wayrilz

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) insufficient response to previous treatment such as oral corticosteroids, IVIG (requires prior authorization) or splenectomy and 2) platelet count less than 30,000 per mm3. Renewal: Medical record documentation of maintenance of platelet counts between 30,000 per mm3 and 150,000 per mm3 or an increase in platelet counts from baseline with resolution of bleeding episodes.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	6 months
Other Criteria	Initial: Failure of eltrombopag (requires prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WINREVAIR

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Documentation of WHO Group 1 pulmonary arterial hypertension diagnosed by right heart catheterization. Renewal: Documentation of clinical improvement or disease stability such as increased exercise capacity, improvement in WHO functional class, or decreased clinical worsening events.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 12 months. Renewal: Lifetime.
Other Criteria	Trial of or contraindication to: 1) sildenafil or tadalafil and 2) bosentan, ambrisentan or macitentan. All require prior authorization.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WYOST

Products Affected

- Wyost

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Preexisting hypocalcemia and 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.

XCOPRI

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

Products Affected

- Xdemvy

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 blepharitis caused by demodex mites.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist.
Coverage Duration	6 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XELJANZ

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er
- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Ankylosing spondylitis (AS) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. AS renewal: improvement in functioning and/or improvement in signs and symptoms of AS. 2) Polyarticular juvenile idiopathic arthritis (pJIA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. pJIA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 3) Psoriatic arthritis (PsA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. PsA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 4) Rheumatoid arthritis (RA) initial: documentation of an inadequate response or intolerance to at least one TNF inhibitor. RA renewal: improved functioning and/or improvement in tender joint count and swollen joint count. 5) Ulcerative Colitis (UC) initial: a) moderate to severe disease activity and b) documentation of an inadequate response or intolerance to at least one TNF inhibitor. UC renewal: medical record documentation of treatment response such as decrease in bloody stools per day, elimination of signs of toxicity, or clinical remission.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with: dermatologist or rheumatologist for PsA, gastroenterologist for UC, rheumatologist for RA, pJIA and AS.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	For oral solution only: documentation of an inability to swallow solid oral dosage forms, or documentation that the tablets are not indicated for the member's age. 1) AS initial: failure of one oral nonsteroidal anti-inflammatory drug such as meloxicam, ibuprofen, naproxen or diclofenac. 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.

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Carcinoid syndrome initial: a) Four or more daily bowel movements despite the use of a somatostatin analog such as octreotide for at least 3 months and b) concurrent use of a somatostatin analog. Renewal: documentation of clinical response to therapy defined as a reduction from baseline in bowel movement frequency.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Renewal: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Preexisting hypocalcemia and 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. 3) Prerequisite therapy is not required for giant cell tumor of bone.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Allergic asthma initial: a) positive skin prick test or in-vitro specific IgE test (such as RAST, MAST, FAST, ELISA) to one or more perennial allergens, b) total serum IgE of 30 -1,300 IU/mL for pediatric patients age 6 to less than 12 years of age or 30 -700 IU/ml for age 12 and above, c) documentation supporting poor asthma control such as multiple asthma exacerbations resulting in repeated uses of health care services including urgent care, ED visits or hospitalizations and/or limitation in activities of daily living. Asthma renewal: reduction in asthma exacerbations and frequency of office visits, ED or urgent care visits, hospitalizations and in the use/need for oral steroids and sustained clinical improvement from baseline. 2) Chronic idiopathic urticaria (CIU) initial: medical record documentation of urticaria for 6 weeks or longer. CIU renewal: documentation of clinical response to Xolair. 3) Nasal polyps (NP) initial: a) documentation that Xolair is being used as add-on therapy, and b) documentation of an inadequate response to nasal corticosteroids. NP renewal: Documentation of clinical benefit from Xolair. 4) IgE-mediated food allergy initial: medical documentation or laboratory result confirmation of: a) IgE-mediate food allergy, b) allergic reaction to one more foods, and c) that Xolair will be used in conjunction with food allergen avoidance. IgE-mediated food allergy renewal: Xolair continues to be used in conjunction with food allergen avoidance.
Age Restrictions	Allergic asthma: 6 years of age or older. Chronic idiopathic urticaria: 12 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with: allergist, immunologist or pulmonologist for allergic asthma, allergist, immunologist or dermatologist for chronic idiopathic urticaria, allergist or immunologist for IgE-mediated food allergy.
Coverage Duration	Initial: 6 months. Asthma, NP, IgE allergy renewal: 12 months. CIU renewal: lifetime.
Other Criteria	1) For the treatment of allergic asthma: failure of, intolerance to or contraindication to a high-dose inhaled corticosteroid and a long-acting beta agonist. 2) For the treatment of chronic idiopathic urticaria: failure of, intolerance to or contraindication to a second-generation

	antihistamines for at least two weeks (failure defined as continued hives and itching).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLREMDI

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.

XROMI

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.

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Genetic testing indicating a deficiency in uridine 5'-monophosphate (UMP) synthase or above normal urine concentration of orotic acid. Renewal: evidence of hematologic improvements.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or metabolic disorder specialist.
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.

XYREM

Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	1) Succinic semialdehyde dehydrogenase deficiency. 2) Concurrent treatment with sedative hypnotics.
Required Medical Information	Renewal: documentation of a reduction in daytime sleepiness or improvement in functioning.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a sleep medicine specialist or neurologist.
Coverage Duration	Initial: 3 months. Renewal: Lifetime.
Other Criteria	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require PA).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XYWAV

Products Affected

- Xywav

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	Prescribed by or in consultation with a sleep medicine specialist.
Coverage Duration	Initial: 3 months. Renewal: Lifetime.
Other Criteria	Narcolepsy, excessive daytime sleepiness (not required for narcolepsy/cataplexy or idiopathic hypersomnia): Failure of or intolerance to: 1) for age 18 years and older, methylphenidate, dextroamphetamine or amphetamine/dextroamphetamine, AND 2) modafinil or armodafinil (both require PA).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YORVIPATH

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

Products Affected

- Yutrepia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Confirmation of a diagnosis of pulmonary arterial hypertension (PAH) WHO group 1 via right heart catheterization with NYHA FC III symptoms, or pulmonary hypertension associated with interstitial lung disease (PH-ILD) WHO Group 3.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Lifetime
Other Criteria	Failure of or contraindication to 1) sildenafil or tadalafil (both require prior authorization) and 2) bosentan or ambrisentan (both require prior authorization).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZAVESCA

Products Affected

- Miglustat
- Yargesa

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) diagnostic conformation by biochemical assay of decreased glucocerebrosidase activity in WBCs or skin fibroblasts, or genotyping revealing two pathogenic mutations of the glucocerebrosidase gene, and 2) Hgb at least 9g/dL and platelet at least 50 x109/L. Renewal: Medical record documentation of stabilization of disease progression such as 1) Improvement in hematologic markers such as increased Hgb/Hct and/or platelet counts or 2) Reduction in spleen or liver volume, or biochemical markers, such as chitotrisidase, ACE, acid phosphatase tartrate resistant (TRAP), or skeletal markers, such as DEXA scan, bone pain.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Dosing consistent with product label: 100mg up to three times a day.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZELSUVMI

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

Products Affected

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

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.

ZILBRYSQ

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.

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Evidence that the patient is currently using standard antibacterial drug treatment according to the FDA approved label.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	180 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOKINVY

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.

ZONISADE

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

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

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.

ZYCUBO

Products Affected

- Zycubo

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 Menkes disease via genetic testing, OR b) documentation of signs and symptoms of Menkes disease, and documentation that testing will delay treatment. Renewal: medical record documentation of a clinical response to therapy, such as improvement in signs and symptoms of Menkes disease.
Age Restrictions	17 years of age or younger
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or specialist with experience treating Menkes disease.
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.

ZYPREXA RELPREVV

Products Affected

- Zyprexa Relprevv

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: currently taking oral olanzapine 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 NOT require use of a prerequisite Part D drug.

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
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 405MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 750MG/100ML, 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 270MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 400MG/100ML; 200MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 300MG/100ML; 570MG/100ML; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Amphotericin B Liposome

- Arformoterol Tartrate
- Azathioprine INJ
- Azathioprine TABS
- Budesonide SUSP
- Cladribine INJ
- 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
- Cyclosporine CAPS
- Cyclosporine Modified CAPS 100MG, 50MG
- Cyclosporine Modified SOLN
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Depo-medrol INJ 20MG/ML
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Ganciclovir INJ 500MG
- Gengraf CAPS 100MG
- Gengraf SOLN
- 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
- Levalbuterol Hydrochloride
- Methylprednisolone TABS
- Methylprednisolone Sodium Succinate
- Methylprednisolone Sodiumsuccinate INJ 40MG
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myhibbin
- Nutrilipid
- 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
- Prehevbrio
- 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
- 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
- Vinblastine Sulfate INJ 1MG/ML

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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