2024 1 Tier Standard - SCHA

2024 Prior Authorization Criteria

CURRENT AS OF 07/01/2024

ABILIFY ASIMTUFII

Products Affected

- ABILIFY ASIMTUFII

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 24419
Last Update: 06/2024

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented trial of, contraindication to, or medical reason for not using at least 2 of the treatment options listed: topical steroids, tazarotene, methotrexate, and cyclosporine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ACTEMRA

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For sJIA, Giant Cell Arteritis and Systemic Sclerosis-Associated Interstitial Lung Disease: Approve
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using 1) oral corticosteroids AND 2) Cortrophin. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using 1) oral or ophthalmic corticosteroids AND 2) Cortrophin. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and IV classification and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micromol/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for Glassia or Aralast NP, the patient has a documented medical reason (such as trial, intolerance or contraindication) for not using Prolastin-C or Zemaira to treat their medical condition.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

APOMORPHINE

Products Affected

- *apomorphine hcl subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If diagnosis is Parkinson's, the patient must have a documented trial of, contraindication to, or medical reason for not using two alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deficiency of interleukein-1 receptor antagonist, documented trial of, contraindication to, or medical reason for not using Kineret. For continuation of therapy or reauthorization: Documentation has been provided that patient has clinically benefited from medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ARISTADA

Products Affected

- ARISTADA INITIO 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML
- ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML,

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

AUVELITY

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	Seizure disorder
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using to two generic antidepressants.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, infectious disease specialist, or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for systemic lupus erythematosus (SLE): concurrent use of two of the following or medical reason for not using glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc.) For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or specialist for submitted diagnosis.
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using Pegasys
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

BOSENTAN

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

BUDESONIDE ER 9 MG

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 24419
Last Update: 06/2024

CAMZYOS

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For all new starts, ALL of the following must be provided: 1) Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (oHCM) AND 2) Patient has a left ventricular ejection fraction (LVEF) greater than or equal to 55% AND 3) Assessment of Valsalva left ventricular outflow tract (LVOT) gradient AND 4) Trial of, medical reason for not using or contraindication to BOTH of the following: Beta blockers (i.e. metoprolol, propranolol, atenolol) AND Non-dihydropyridine calcium channel blockers (i.e. verapamil, diltiazem) AND 5) Prescriber attests that patient is not using moderate to strong CYP2C19 or CYP3A4 inhibitors or inducers. For continuation of therapy or reauthorization, all of the following must be provided: 1) Documentation of clinical benefit as evidenced by an improvement from baseline in oHCM symptoms (i.e., improvement in fatigue, chest pain, shortness of breath, LVOT, peak oxygen consumption, etc.) OR improvement or no worsening of NYHA functional class AND 2) Member must also have a left ventricular ejection fraction (LVEF) greater than or equal to 50%.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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PA Criteria	Criteria Details
Part B Prerequisite	No

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CASPOFUNGIN

Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status.
Required Medical Information	Patient's CYP2D6 metabolizer status, as determined by an FDA approved test. For reauthorization, documentation has been provided that patient has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, PFTs, improvement in radiographic scans, improved quality of life).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CGRP ANTAGONISTS

Products Affected

- AIMOVIG
- EMGALITY
- EMGALITY (300 MG DOSE)
- NURTEC
- QULIPTA
- UBRELVY
- ZAVZPRET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For acute migraine new starts - for Ubrelvy and Nurtec requests, must have trial of, contraindication to or medical reason for not using a triptan. For migraine prophylaxis new starts - 1) at least 4 migraine days per month or one or more severe migraine attacks lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs) and 2) trial of, contraindication to, or medical reason for not using at least two of the following agents: a beta adrenergic blocker, an anti-epileptic agent, a tricyclic antidepressant, or a serotonin-norepinephrine reuptake inhibitor. For Emgality requests for episodic cluster headache new starts - must have trial of, contraindication to, or a medical reason for not using verapamil for at least 4 weeks at minimum effective doses. For continuation of therapy or reauthorization - For acute migraine (Nurtec, Ubrelvy), must show documentation of improvement in migraine symptoms (pain, photophobia, phonophobia). For migraine prevention (Nurtec, Emgality, Qulipta, Aimovig), must show a benefit of 1 headache day per month reduction since initiation of therapy. For episodic cluster headache treatment, must show documentation of reduction in frequency of headaches
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off-Label Uses	N/A
Part B Prerequisite	No

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: Patient has documented diagnosis of either: 1) bile acid synthesis disorder due to a single enzyme defect or 2) peroxisomal disorders. For continuation of therapy or reauthorization: prescriber attests: 1) the patient has clinical improvement with therapy (i.e. liver function tests) AND 2) there is no evidence of biliary obstruction or cholestasis
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, or metabolic specialist
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CIBINQO

Products Affected

- CIBINQO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For atopic dermatitis: Trial of, contraindication to, or medical reason for not using Rinvoq
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CIMZIA

Products Affected

- CIMZIA (2 SYRINGE)
- CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Humira, Hadlima, Skyrizi or Stelara or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Skyrizi, Tremfya, Stelara, Enbrel, Hadlima, or Humira 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy

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PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) Blood pressure greater than or equal to 90/50 mmHg
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not receiving a beta blocker.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CORTROPHIN

Products Affected

- CORTROPHIN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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COSENTYX

Products Affected

- COSENTYX
- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For enthesitis-related arthritis: approve. For moderate to severe hidradenitis suppurativa (HS): Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 1 of the following therapies: Hadlima or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off-Label Uses	N/A
Part B Prerequisite	No

CYSTAGON

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis for cystinosis with corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or metabolic disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DALFAMPRIDINE ER

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure or moderate/severe renal impairment (CrCl less than or equal to 50 mL/min).
Required Medical Information	For new starts: 1) Attestation that creatinine clearance (CrCl) greater than 50 mL/min was confirmed prior to initiation of therapy, AND 2) Documentation has been provided that member is ambulatory (able to walk at least 25 feet) and has a documented walking impairment, AND 3) For appropriate indications, member is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc.) or has a medical reason why member is unable to use a disease modifying agent for their condition. For continuation of therapy or re-authorization requests: 1) Member must experience improvement in walking from baseline due to use of dalfampridine ER.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DEFERASIROX

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Creatinine clearance less than 40 mL/min or platelet counts less than 50,000/mm3.
Required Medical Information	For all indications: platelet count greater than or equal to 50,000/mm3 (within 30 days) and creatinine clearance greater than or equal to 40 mL/min. For chronic iron overload due to transfusions: serum ferritin concentration greater than 1000 mcg/L (lab result with 30 days). For chronic iron overload in non-transfusion-dependent thalassemia syndromes: serum ferritin concentration greater than 300 mcg/L (lab result with 30 days).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deferasirox granules oral packets, the member must have medical reason for not using deferasirox tablets or oral soluble tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DEFERIPRONE

Products Affected

- *deferiprone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request, and 2) Trial of, contraindication to, or medical reason for not using deferasirox tablets. For continuation of therapy or reauthorization, decrease in serum ferritin from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For members 2 years and older: Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications. For members under 2 years old: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DICHLORPHENAMIDE

Products Affected

- *dichlorphenamide*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, neurologist, or endocrinologist.
Coverage Duration	New starts will be authorized for 2 months. Cont of therapy or reauth until end of contract year.
Other Criteria	Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

DIFICID

Products Affected

- DIFICID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 10 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DOPTELET

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for chronic liver disease and chronic immune thrombocytopenia (chronic ITP): documented baseline platelet count of less than 50,000/mcL.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hematologist, hepatologist or surgeon.
Coverage Duration	For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year
Other Criteria	For chronic ITP: trial of, contraindication to, or medical reason for not using a corticosteroid. For thrombocytopenia with chronic liver disease (CLD): approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DOXEPIN CREAM

Products Affected

- *doxepin hcl external*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 1 month.
Other Criteria	Trial of, contraindication to, or medical reason for not using a topical corticosteroid or topical calcineurin inhibitor.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for atopic dermatitis in patients 2 years old or older: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. New starts for atopic dermatitis in patients less than 2 years old: trial of, contraindication to, or medical reason for not using Eucrisa. New starts for asthma with eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter, and 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). New starts for oral corticosteroid dependent asthma: symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment, (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal corticosteroids OR member has had prior surgery for nasal polyps. New starts for eosinophilic esophagitis: 1) diagnosis has been confirmed by esophageal biopsy and 2) patient has inadequate response to conventional therapies (i.e. proton pump inhibitors, topical corticosteroids, or oral corticosteroids). New starts for prurigo nodularis: attestation is provided

PA Criteria	Criteria Details
	confirming diagnosis. Continuation of therapy or reauthorization for all indications: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EGRIFTA

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with SSRIs, SNRIs, clomipramine and imipramine, meperidine, tramadol, methadone, pentazocine, and propoxyphene, and the antitussive agent dextromethorphan or carbamazepine
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: Trial of, contraindication to, or medical reason for not using two generic antidepressants.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that two or more painful sickle cell crises have occurred in the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using hydroxyurea for at least three months.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ENTYVIO

Products Affected

- ENTYVIO SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Hadlima or Humira. 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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EPRONTIA

Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using topiramate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ERYTHROPOETIN STIMULATING AGENTS

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for all indications: Hgb within compendia range for treatment of the requested medical condition. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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EUCRISA

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For continuation of therapy or reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FABHALTA

Products Affected

- FABHALTA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma with an eosinophilic phenotype: 1)Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FENTANYL CITRATE TRANSMUCOSAL PRODUCTS

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation must be provided for the all of the following: 1) fentanyl citrate oral transmucosal is being prescribed to treat cancer-related breakthrough pain AND 2) Patient has been taking opioids at a dose equal to 60 MME per day for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FILSPARI

Products Affected

- FILSPARI

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists, or aliskiren
Required Medical Information	For new starts: Attestation that member has diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m(2) and proteinuria. For continuation of therapy or reauthorization: Documentation of positive clinical response (ie. decrease in urine protein-to-creatinine ratio (UPCR)).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	New starts will be authorized for 9 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FIRDAPSE

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FLUCYTOSINE

Products Affected

- *flucytosine oral*

PA Criteria	Criteria Details
Exclusion Criteria	Complete dihydropyrimidine dehydrogenase (DPD) enzyme deficiency
Required Medical Information	Attestation member is taking in combination with amphotericin B.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

FLUOROURACIL

Products Affected

- *fluorouracil external cream 0.5 %*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or oncologist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation of 1) Colonoscopy of full colon with removal of polyps within six months prior to starting treatment for adults or 2) Fecal occult blood testing within six months prior to starting treatment for pediatric patients. For continuation of therapy or reauthorization: Documentation is provided that the member has obtained a clinical benefit (e.g. reduction in parenteral fluid volume, reduction in number of days receiving parenteral nutrition).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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GNRH AGONISTS

Products Affected

- CAMCEVI
- ELIGARD
- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- *leuprolide acetate (3 month)*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard or leuprolide, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard or leuprolide to treat their prostate cancer.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
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	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts: trial of, contraindication to, or medical reason for not using generic amantadine. Continuation of therapy or reauthorization: Member demonstrates clinical benefit (i.e. improvement in levodopa-induced dyskinesia or decreased off episodes).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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GROWTH HORMONES

Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NGENLA
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for growth hormone deficiency: Documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off-Label Uses	N/A
Part B Prerequisite	No

HADLIMA

Products Affected

- HADLIMA
- HADLIMA PUSHTOUCH

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfsalazine, methotrexate or corticosteroid (e.g., prednisone, methylprednisolone). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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HEREDITARY ANGIOEDEMA AGENTS

Products Affected

- CINRYZE
- HAEGARDA
- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an allergist, immunologist, rheumatologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For continuation of therapy or reauthorization: Documentation has been provided that patient has clinically benefited from medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

HETLIOZ

Products Affected

- HETLIOZ LQ
- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts of non-24 hour sleep-wake cycle: 1) Member is totally blind with no perception of light, 2) diagnosis of non-24 confirmed by a physiologic circadian phase marker (ex: dim light melatonin onset, assessment of core body temp or measurement of urinary melatonin levels) OR actigraphy with evaluation of sleep logs. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug. For night-time sleep disturbances in Smith-Magenis Syndrome (SMS): approve
Age Restrictions	N/A
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

HIGH RISK MEDICATION

Products Affected

- *clemastine fumarate oral tablet 2.68 mg*
- *cyproheptadine hcl oral*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg*
- *glyburide-metformin oral tablet 5-500 mg*
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet 25 mg, 50 mg*
- *hydroxyzine pamoate oral*
- *indomethacin er*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension*
- *nifedipine oral*
- NORPACE CR
- *pentazocine-naloxone hcl*
- *promethazine hcl oral solution*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine vc*
- *promethazine-phenylephrine*
- *promethegan rectal suppository 50 mg*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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PA Criteria	Criteria Details
Part B Prerequisite	No

HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *megestrol acetate oral tablet*
- MENEST
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*
- *protriptyline hcl*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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HIGH RISK MEDICATION, BUTALBITAL

Products Affected

- *ascomp-codeine*
- *bac*
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using an oral NSAID.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

Products Affected

- *carisoprodol oral*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral tablet 500 mg, 750 mg*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 30 days. Continuation of therapy or reauth will be for 90 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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HIGH RISK MEDICATION, SLEEP AGENTS

Products Affected

- *eszopiclone*
- *temazepam*
- *zaleplon*
- *zolpidem tartrate er*
- *zolpidem tartrate oral tablet 10 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored. For zolpidem immediate release 10mg and zolpidem ER: trial of or medical reason for not using zolpidem immediate release 5mg.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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HUMIRA

Products Affected

- HUMIRA (2 PEN)
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML
- HUMIRA-PED<40KG CROHNS STARTER
- HUMIRA-PED>/=40KG CROHNS START
- HUMIRA-PED>/=40KG UC STARTER
- HUMIRA-PS/UV/ADOL HS STARTER
- HUMIRA-PSORIASIS/UVEIT STARTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfsalazine, methotrexate or corticosteroid (e.g., prednisone, methylprednisolone). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.

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PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

HYFTOR

Products Affected

- HYFTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of diagnosis of tuberous sclerosis with facial angiofibroma. For continuation of therapy or reauthorization: documentation that the member has experienced a clinical benefit from treatment (e.g. improvement in size and color of angiofibroma).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or provider who specializes in the treatment of genetic or dermatologic disorders.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ICATIBANT

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, allergist, rheumatologist, or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ICOSAPENT

Products Affected

- *icosapent ethyl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For a diagnosis of hypertriglyceridemia: Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose OR documented statin intolerance AND omega-3-acid ethyl esters capsule. For a diagnosis of cardiovascular risk reduction, ALL the following are required: 1) Documentation of hypertriglyceridemia greater than or equal to 150 mg/dL: 2) Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose for 3 months OR documented statin intolerance AND 3) Documentation of one of the following: Established atherosclerotic cardiovascular disease (e.g., coronary artery disease, cerebrovascular accident, carotid disease, peripheral artery disease) OR age greater than or equal to 50 years old with established diabetes and at least one additional risk factor for cardiovascular disease (e.g., hypertension, renal dysfunction, retinopathy, albuminuria, males age greater than or equal to 55 years old or females age greater than or equal to 65 years old).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ILARIS

Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test)
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sJIA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ILUMYA

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts for treatment of graft-versus-host disease (GVHD): Trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of for treatment of GVHD: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For all other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

INTRON-A

Products Affected

- INTRON A INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts for treatment of graft-versus-host disease (GVHD): Trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of for treatment of GVHD: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For all other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

JYLAMVO

Products Affected

- JYLAMVO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, a rheumatologist, a dermatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of diagnosis of chronic kidney disease due to type 2 diabetes mellitus AND 2) Documentation of serum potassium levels less than or equal to 5 mEq/L AND 3) eGFR greater than or equal to 25ml/min/1.73 m2 AND 4) Documentation that member is taking Kerendia in combination with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB AND 4) Documented trial of, contraindication to, or medical reason for not using a sodium-glucose cotransporter-2 (SGLT2) inhibitor. For continuation of therapy or reauthorization: 1) Documentation of serum potassium levels less than or equal to 5.5 mEq/L AND 2) Documentation that member is taking Kerendia in combination with an ACEi or ARB at maximum tolerated doses or documentation has been provided that the member is unable to tolerate ACEi or ARB.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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KEVZARA

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For polymyalgia rheumatica (PMR): Trial of, medical reason for not using, or contraindication to corticosteroids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For cryopyrin-associated periodic syndromes or deficiency of interleukin-1 receptor antagonist: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

KORLYM

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus.
Required Medical Information	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus or tacrolimus concurrently with mifepristone.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LITFULO

Products Affected

- LITFULO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LIVMARLI

Products Affected

- LIVMARLI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Trial of, contraindication to, or medical reason for not using both of the following: cholestyramine AND rifampin. 2) Prescriber attests that the member has cholestasis 3) Baseline serum bile acid level is provided. 4) Documentation of patients weight. For continuation of therapy or reauthorization: 1) Documentation submitted indicating the member has had all of the following: an improvement in pruritis (e.g. improved observed scratching, decreased sleep disturbances/nighttime awakenings due to scratching, etc.) AND reduction in serum bile acid level from baseline. 2) Prescriber attests that patient has had no evidence of hepatic decompensation (e.g. variceal hemorrhage, ascites, hepatic encephalopathy, portal hypertension, etc.). 3) Documentation of patients weight.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LODOCO

Products Affected

- LODOCO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be, or in consultation with a specialist in the treatment of cardiovascular disease, such as a cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation that patient has established atherosclerotic disease or multiple risk factors for cardiovascular disease AND documentation that patient does not have pre-existing blood dyscrasias (ex. leukopenia, thrombocytopenia) and patient does not have renal failure (CrCl less than 15 ml/min) or severe hepatic impairment
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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LUCEMYRA

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	For new starts, patient must have trial of, contraindication to, or medical reason for not using clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with cyclophosphamide.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Documentation of urine protein/creatinine ratio (UPCR), 2) Documentation that the member has a baseline eGFR greater than 45 mL/min/1.73m2 or that benefit outweighs risk of using this medication at current eGFR, and 3) Concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization: Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR greater than or equal to 20%).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

LYBALVI

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with opioids.
Required Medical Information	Attestation from the provider that the member has had an opioid-free period of a minimum of 7 days after last use of shorting-acting opioids and 14 days from last use of long-acting opioids before initiating Lybalvi.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using at least two generic antipsychotics, one of which must be generic olanzapine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MANNITOL INHALATION

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of one of the following: 1) Concurrent use of alpha adrenergic blockers, 2) Medical reason for being unable to use an alpha adrenergic blocker, OR 3) Patient is not a candidate for surgical resection and requires long term treatment with metyrosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, documentation of diagnosis for mild to moderate type 1 Gaucher disease. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug (i.e. increased platelet count, improvement in anemia, PFT's, improvement in radiographic scans, improved quality of life).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MULTIPLE SCLEROSIS AGENTS

Products Affected

- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack oral capsule delayed release therapy pack*
- *fingolimod hcl*
- *glatiramer acetate*
- *glatopa*
- KESIMPTA
- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)
- MAYZENT
- MAYZENT STARTER PACK
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TASCENSO ODT
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the member is over 17 years of age and the request is not for glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using both dimethyl fumarate AND glatiramer

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PA Criteria	Criteria Details
	or Glatopa. If the request is for fingolimod and the member is 17 years of age or younger, the request will be approved.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

MYFEMBREE

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for menorrhagia: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. New starts for endometriosis: Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline, pain relief).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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NASAL ANTISEIZURE AGENTS

Products Affected

- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
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	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber is an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia the following are required: 1) Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) OR primary hyperlipidemia. In addition to the initial criteria above if the new start is for cardiovascular risk reduction, the following are required: 1) Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral artery disease, and/or cerebrovascular atherosclerotic disease, 2) Member does not have established cardiovascular disease but is considered high risk (one of the following): Diabetes Mellitus (Type 1 or Type 2) in females over 65 years of age or males over 60 years of age OR a Reynolds Risk score greater than 30% or a SCORE Risk score greater than 7.5% over 10 years OR a coronary artery calcium score greater than 400 Agaston units at any time in the past, 3) Member has a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all

PA Criteria	Criteria Details
	indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia the following are required: 1) Member has a diagnosis of heterozygous familial hypercholesterolemia (FH) OR primary hyperlipidemia. In addition to the initial criteria above if the new start is for cardiovascular risk reduction, the following are required: 1) Member has established cardiovascular disease (documented history of coronary artery disease, symptomatic peripheral artery disease, and/or cerebrovascular atherosclerotic disease, 2) Member does not have established cardiovascular disease but is considered high risk (one of the following): Diabetes Mellitus (Type 1 or Type 2) in females over 65 years of age or males over 60 years of age OR a Reynolds Risk score greater than 30% or a SCORE Risk score greater than 7.5% over 10 years OR a coronary artery calcium score greater than 400 Agaston units at any time in the past, 3) Member has a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all

PA Criteria	Criteria Details
	indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- *armodafinil*
- *modafinil oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma: 1) Baseline blood eosinophil count greater than or equal to 150 cells per microliter AND 2) symptoms with equal to or greater than 1 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) while on a high-dose inhaled corticosteroid with an additional controller medication (ie. long-acting B2 agonist). New starts for eosinophilic granulomatosis with polyangiitis (EGPA): trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. New starts for hypereosinophilic syndrome without an identifiable non-hematologic secondary cause: 1) 2 or more flares within the past 12 months AND 2) trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal corticosteroids OR member has had prior surgery for nasal polyps. Continuation of therapy or re-authorization for all indications: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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PA Criteria	Criteria Details
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Complete atrioventricular (AV) block without implanted pacemaker, or at high risk of complete AV block. History of heart failure. Concomitant use with MAOIs or use of MAOIs within 14 days. Concomitant use with drugs containing quinidine, quinine, or mefloquine. History of quinine-, mefloquine-, dextromethorphan/quinidine-, or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome. Non-Part D indications.
Required Medical Information	Confirmation diagnosis is for Part D indication.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Members with decompensated cirrhosis, a prior decompensation event, compensated cirrhosis who have evidence of portal hypertension, or complete biliary obstruction.
Required Medical Information	For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request. For continuation of therapy or reauthorization: Documentation that that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for acromegaly: pt meets one of the following (1) inadequate response to surgery and/or radiotherapy OR (2) pt is not an appropriate candidate for surgery and/or radiotherapy OR (3) pt is experiencing negative effects due to tumor size (ex: optic nerve compression). Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For a diagnosis of idiopathic pulmonary fibrosis: 1) Documentation of disease as demonstrated on a high resolution CT scan or through lung biopsy and 2) Documented trial of, contraindication to, or medical reason for not using pirfenidone. For a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD): documented trial of, contraindication to, or medical reason for not using mycophenolate mofetil or cyclophosphamide. For a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype: documentation is provided confirming diagnosis.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OLUMIANT

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For alopecia areata: Documentation of confirmed diagnosis and other causes of hair loss have been ruled out.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using sildenafil.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ORAL ANTINEOPLASTIC AGENTS

Products Affected

- *abiraterone acetate*
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- EXKIVITY
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate*
- IMBRUVICA
- INLYTA
- INQOVI
- INREBIC
- IWILFIN
- JAYPIRCA
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (200 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG 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)
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- NERLYNX
- *nilutamide*
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl*

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- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- PURIXAN
- QINLOCK
- RETEVMO
- REVLIMID
- REZLIDHIA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- SOLTAMOX
- *sorafenib tosylate*
- SPRYCEL
- STIVARGA
- *sunitinib malate*
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- *toremifene citrate*
- *tretinoin oral*
- TRUQAP
- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)
- TUKYSA
- TURALIO
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A

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PA Criteria	Criteria Details
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORAL ANTIPSYCHOTICS

Products Affected

- CAPLYTA
- FANAPT
- FANAPT TITRATION PACK
- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia and manic or mixed episodes associated with bipolar l disorder and major depressive disorder associated with bipolar l or II disorder: trial of, contraindication to, or medical reason for not using two generic antipsychotics. If the request is for Vraylar for major depressive disorder: provider attestation that the member is concurrently using an antidepressant.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For acute graft versus host disease: Attestation member is taking in combination with a calcineurin inhibitor and methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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Last Update: 06/2024

ORIAHNN

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB, gynecologist or reproductive endocrinologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ORILISSA

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has osteoporosis or severe hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB or gynecologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years for 150mg tablet or 6 months for 200mg tablet, and 2) Documentation has been provided that the member has obtained clinical benefit from the medication.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to lumacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For moderate to severe psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For Behcet's Syndrome or mild psoriasis: Approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OXBRYTA

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts: Documentation is provided for all of the following: 1) baseline labs: Hemoglobin (Hb) level less than 10.5 g/dL, indirect bilirubin, and reticulocytes, 2) member has had 1 or more pain crises in the last 12 months, and 3) member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea). Continuation of therapy or reauthorization at 6 months from initiation and at subsequent 12-month intervals: Documentation of 1 of the following: 1) Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter), or 2) reduced number of vaso-occlusive/pain crises since Oxbryta was started, or 3) decrease in indirect bilirubin from baseline, or decrease in percentage of reticulocytes from baseline.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an ophthalmologist.
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

OXYCODONE ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be excluded from the concurrent benzodiazepine and muscle relaxant therapy requirement. For new starts, ALL of the following are required: (1) Member has documented history of receiving an immediate-release opioid, (2) Member has a documented trial of, contraindication to, or medical reason for not using long-acting morphine sulfate, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off-Label Uses	N/A
Part B Prerequisite	No

PALIPERIDONE INJECTABLE

Products Affected

- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML
- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 24419
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PALIPERIDONE ORAL

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using an alternative generic second generation atypical antipsychotic.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PCSK9 INHIBITORS

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For ALL diagnoses (including primary hyperlipidemia) for new starts, attestations of the following: 1) Two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies, and 2) If patient experiences statin intolerance, trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with attestation of return of side effects. For familial hypercholesterolemia (FH), attestation of TWO of the following: 1) genetic testing confirming FH diagnosis, 2) clinical manifestations of FH such as xanthomas or inflamed tendons, 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). For ASCVD, additional attestation of history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic

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PA Criteria	Criteria Details
	origin. For ALL diagnoses for continuation of therapy or reauthorization: attestation of improvement in LDL from new start.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PEGINTERFERON

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C: 1) Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. 2) Documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: 1) Labs within 3 months of request: ALT/AST, and 2) HBeAg status. For polycythemia vera, approve.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for 24 to 48 weeks as defined by compendia.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz. For other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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PENTAMIDINE SOLUTION FOR INJECTION

Products Affected

- *pentamidine isethionate injection*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PERSERIS

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using doxazosin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PIRFENIDONE

Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis, documentaton of all of the following: 1) confirmation of diagnosis on high resolution CT scan or through lung biopsy AND 2) FVC greater than or equal to 50% of the predicted value.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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POSACONAZOLE

Products Affected

- *posaconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist, a transplant specialist, or an oncologist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis: trial of, contraindication to, or medical reason for not using fluconazole or itraconazole. For prophylaxis of invasive aspergillus infections due to being severely immunocompromised: trial of, contraindication to, or medical reason for not using voriconazole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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PRETOMANID

Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Required Medical Information	Documentation of use in combination with bedaquiline and linezolid.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 26 weeks.
Other Criteria	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

PROMACTA

Products Affected

- PROMACTA ORAL PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For chronic immune (idiopathic) thrombocytopenia (ITP): Documented baseline platelet count less than 30,000 cells/ microL. For severe aplastic anemia: Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 75,000 cells/microL.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For chronic immune (idiopathic) thrombocytopenia (ITP):Trial of, contraindication to, or medical reason for not using glucocorticosteroids. For severe aplastic anemia: Trial of, contraindication to, or medical reason for not using at least one immunosuppressive agent.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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PYRUKYND

Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: 1) documentation of diagnosis and 2) baseline hemoglobin level. For continuation of therapy or reauthorization: documentation of clinical improvement (e.g. reduction in number of blood transfusions, or increase or stabilization in hemoglobin level). If the criteria are not met, may authorize up to 14 days of a Pyrukynd Taper Pack to allow for tapering.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	New starts: 6 mo. Cont of therapy or reauth: end of contract yr. Denial: 14 days for dose tapering.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RADICAVA

Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: 1) documentation of ALS functional rating scale (ALSFRS-R) score and 2) documentation that the member has been on riluzole, is beginning therapy as an adjunct to treatment with Radicava, or provider has provided a medical reason why patient is unable to use riluzole. For continuation of therapy or reauthorization: documentation from provider of clinical stabilization in symptoms (e.g. stabilization of ALS functional rating scale (ALSFRS-R) score).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using sodium phenylbutyrate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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RECORLEV

Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using ketoconazole tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 20 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RELISTOR

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial of or medical reason for not using the following: 1) lubiprostone, AND 2) lactulose AND 3) Movantik. Additionally, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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RELYVRIO

Products Affected

- RELYVRIO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: Documentation of diagnosis of ALS. For continuation of therapy or reauthorization: Documentation or provider attestation of positive clinical response (such as improvement in the Revised ALS Functional Rating Scale (ALSFRS-R) total score)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using two generic antipsychotics. For major depressive disorder: trial of, contraindication to, or medical reason for not using to two generic antidepressants. For agitation associated with dementia: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or transplant specialist.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: documented trial of, contraindication to, or medical reason for not using at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, tacrolimus, mycophenolate mofetil, Imbruvica, or Jakafi), one of which must be a systemic corticosteroid. For continuation of therapy or re-authorization: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel, Hadlima, or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel, Hadlima, or Humira). For atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel, Hadlima, or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira, or Hadlima. For non-radiographic axial spondyloarthritis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: trial of, medical reason for not using, or contraindication to 1 TNF blocker.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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PA Criteria	Criteria Details
Part B Prerequisite	No

RISPERIDONE INJECTABLE

Products Affected

- *risperidone microspheres er*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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RUFINAMIDE

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	History of familial Short QT syndrome
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one alternative generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RYKINDO

Products Affected

- RYKINDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

RYLAZE

Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, hematologist, or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SAPROPTERIN

Products Affected

- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of elevated baseline phenylalanine levels. Continuation of therapy or reauthorization: prescriber attests the member has improvement in phenylalanine levels from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using to one generic antipsychotics.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a HIV specialist, gastroenterologist, nutritional support specialist or ID specialist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	For initial starts for HIV wasting/cachexia: 1) Member must be on anti-retroviral therapy and 2) Trial of, contraindication to or medical reason for not using megestrol or dronabinol and 3) Alternative causes of wasting have been ruled out (diarrhea, malignancies, inadequate caloric intake, etc)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Member is not a candidate for surgery or surgery was not curative.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SILDENAFIL ORAL

Products Affected

- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SILIQ

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Humira, Hadlima, Rinvoq, Stelara or Xeljanz or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking 3 additional antimycobacterial drugs in combination to treat MDR-TB.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SKYRIZI

Products Affected

- SKYRIZI
- SKYRIZI PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA or psoriasis: approve. For Crohns Disease: Either 1) Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, sulfsalazine, methotrexate or corticosteroid (e.g., prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SODIUM PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SOFOSBUVIR/VELPATASVIR

Products Affected

- SOFOSBUVIR-VELPATASVIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for acromegaly: pt meets one of the following (1) inadequate response to surgery and/or radiotherapy OR (2) pt is not an appropriate candidate for surgery and/or radiotherapy OR (3) pt is experiencing negative effects due to tumor size (ex: optic nerve compression). Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SOTYKTU

Products Affected

- SOTYKTU

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For moderate to severe psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

STELARA

Products Affected

- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Crohns Disease: Either 1) Trial of, medical reason for not using (i.e. severe Crohns disease), or contraindication to 1 of the following: mercaptopurine, azathioprine, methotrexate, sulfasalazine, or corticosteroid (e.g., prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Approve. For PsA: Approve. For UC: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of diagnosis of congenital sucrase-isomaltase deficiency. For continuation of therapy or reauthorization: Prescriber attests that member has obtained a clinical benefit (e.g. fewer total stools, greater number of hard and formed stools, fewer watery and soft stools, decrease in breath hydrogen output)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SYMLIN

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Patient has confirmed gastroparesis.
Required Medical Information	For new starts: HbA1C values within 90 days of request is greater than or equal to 7% despite receiving insulin therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using two alternative anti-diabetic agents.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), OR gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TADALAFIL

Products Affected

- *tadalafil (pah)*
- TADLIQ

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Tadliq: Documentation of trial of, contraindication to, or medical reason for not using tadalafil tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Enbrel, Humira, Hadlima, Rinvoq or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Stelara, Skyrizi, Tremfya, Xeljanz, Rinvoq, Enbrel, Hadlima, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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TARPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation that member has 1) Diagnosis of primary immunoglobulin A nephropathy (IgAN) and 2) at risk of disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m(2) and proteinuria. For continuation of therapy: documentation that member has been on Tarpeyo for less than 9 months. For reauthorizations: Requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Request will be authorized for 9 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Prescriber attests that Tavneos will be prescribed in combination with corticosteroids AND cyclophosphamide unless there is documented trial of, contraindication to, or medical reason for not using these therapies. 2) Documentation of baseline Birmingham Vasculitis Activity Score (BVAS) score 3) Prescriber attestation that the patient will have liver function tests before treatment (ALT, AST, alkaline phosphate, and total bilirubin) and every 4 weeks after start of therapy for the first 6 months of treatment 4) Prescriber attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) infection at baseline. For continuation of therapy or reauthorization: 1) Documentation of remission (BVAS score of 0) OR improvement in BVAS score 2) Prescriber attestation that patient has no abnormality in liver function tests (abnormality: ALT or AST greater than 3 times the upper limit of normal and bilirubin greater than 2 times the upper limit of normal) 3) Prescriber attestation that patient has no active HBV infection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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TEFLARO

Products Affected

- TEFLARO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TERIPARATIDE

Products Affected

- TERIPARATIDE
- TERIPARATIDE (RECOMBINANT)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: 1) Trial of, medical reason for not using, or contraindication to an oral bisphosphonate and Prolia and 2) therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

THIOLA

Products Affected

- THIOLA EC
- *tiopronin oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TOLVAPTAN

Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A4 inhibitors (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using a strong CYP3A4 inhibitor (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or nephrologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TOPICAL ANTINEOPLASTIC RETINOIDS

Products Affected

- *bexarotene*
- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TOPICAL TESTOSTERONE

Products Affected

- *testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of prostate cancer or breast cancer.
Required Medical Information	New starts of topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two separate instances of low serum total or free testosterone taken in the morning, as defined by the lab reference range.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TRANSDERMAL LIDOCAINE

Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for the product ZTlido, must provide medical reason for not being able to use generic lidocaine 5% patch
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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TREMFYA

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA or psoriasis: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TRIENTINE

Products Affected

- CUVRIOR
- *trientine hcl oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for Cuvrior for new starts, member must have trial of, contraindication to, or medical reason for not using trientine hydrochloride.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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TRIKAFTA

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Symdeko.
Required Medical Information	Documentation of CFTR gene that is responsive to elexacaftor-tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or patient has had an osteoporotic fracture or patient has T-scores from -1.5 to -2.5 at the femoral neck or spine, and a 10-year probability of hip fracture greater than or equal to 3% or a 10-year probability of any major osteoporosis-related fracture greater than or equal to 20% based on the United States-adapted FRAX model.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: 1) trial of, contraindication to, or medical reason for not using an oral bisphosphonate and Prolia, and 2) therapy does not exceed 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

TYVASO

Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For the treatment of pulmonary arterial hypertension (PAH): 1) documentation of PAH WHO Group I classification and PAH Functional Class and 2) trial of, contraindication to, or medical reason for not using a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist. For the treatment of pulmonary hypertension associated with interstitial lung disease (PH-ILD, WHO Group 3): documentation of PH-ILD and PAH Functional Class.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

UPTRAVI

Products Affected

- UPTRAVI ORAL
- UPTRAVI TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using a generic phosphodiesterase inhibitor and a generic endothelin receptor antagonist.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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UZEDY

Products Affected

- UZEDY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not being able to use one of the following: a topical corticosteroids or a topical retinoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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Last Update: 06/2024

VEMLIDY

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation that member has been tested for HIV infection. If member is HIV-positive, Vemlidy is not used alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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VIGABATRIN

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For infantile spasms or West syndrome, the request will be approved. For diagnosis of refractory complex partial seizures: 1) documentation of diagnosis, and 2) attestation the member is currently receiving another antiepileptic drug, and 3) attestation the member has experienced treatment failure from two generic alternative formulary antiepileptic agents.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VIJOICE

Products Affected

- VIJOICE ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Member has at least one target lesion identified on imaging AND 3) Prescriber attests the patient's condition is severe or life-threatening and necessitates systemic treatment. For continuation of therapy or reauthorization, attestation of a positive clinical response (i.e. reduction in the sum of measurable target lesion volume, absence of progression of non-target lesions, absence of any new lesions, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, dermatologist, vascular surgeon, hematologist/oncologist, or other specialist in the treatment of PIK3CA-Related Overgrowth Spectrum(PROS).
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VMAT-2 INHIBITORS

Products Affected

- AUSTEDO
- AUSTEDO PATIENT TITRATION KIT
- INGREZZA ORAL CAPSULE
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, clinical geneticist, or psychiatrist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for tetrabenazine, request will be approved. If the request is for Ingrezza and Austedo, the member must have trial of or medical reason for not using the tetrabenazine. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 24419
Last Update: 06/2024

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	Non-Part D indications.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Detectable HCV RNA viral load prior to treatment within 6 months of request. In addition, documentation of treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

VOWST

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of Clostridioides difficile infection (CDI)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all the criteria are met, the request will be approved for 1 month
Other Criteria	Diagnosis of at least 1 recurrent episode of CDI
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

Formulary ID 24419
Last Update: 06/2024

WEGOVY

Products Affected

- WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML

PA Criteria	Criteria Details
Exclusion Criteria	The member has an indication of only weight reduction or maintenance for overweight or obesity. The member has concurrent use of any GLP-1 receptor agonist. The member has a personal history of Type 1 or Type 2 diabetes. The member has a personal history of medullary thyroid carcinoma. The member has Multiple Endocrine Neoplasia syndrome type 2.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For initial requests: approve for 6 months. For re-authorization requests: approve for 12 months.
Other Criteria	For new starts: The member has an indication for reducing the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease. Documentation demonstrates patient has history of one or more of the following: 1) prior myocardial infarction 2) prior stroke 3) symptomatic peripheral arterial disease as evidenced by 1 or more of the following: 1) intermittent claudication with ankle brachial index less than 0.85 (at rest), 2) peripheral arterial revascularization procedure, 3) amputation due to atherosclerotic disease. Documentation is provided that the patient is overweight or obese (defined as a BMI of greater than or equal to 27 kg/m2). Documentation is provided that the patient's Hb A1c is less than or equal to 6.5%. For continuation of therapy or reauthorization: Documentation is provided that the patient's Hb A1c is less than or equal to 6.5%. Patient continues to not have Type 1 or Type 2 diabetes.
Indications	All Medically-accepted Indications.

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PA Criteria	Criteria Details
Off-Label Uses	N/A
Part B Prerequisite	No

WHITE BLOOD CELL STIMULATORS

Products Affected

- FULPHILA
- FYLNETRA
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NYVEPRIA
- UDENYCA
- UDENYCA ONBODY
- ZARXIO
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for Neulasta, Fulphila, Udenyca and Nyvepria: documentation of trial of, contraindication to, or medical reason for not using Fylnetra and Ziextenzo. Continuation of therapy or re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel, Hadlima, or Humira) For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 TNF blocker (Enbrel, Hadlima, or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel, Hadlima, or Humira). For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel, Hadlima, or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira or Hadlima.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) Attestation that diarrhea is inadequately controlled by stable dose of SSA therapy for at least three months. For continuation of therapy or reauthorization: 1) documentation of positive clinical response to xermelo and 2) Attestation to continue to be used in combination with SSA.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	New starts: Serum calcium levels. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For HE: gastroenterologist or hepatologist. For IBS-D: gastroenterologist.
Coverage Duration	For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.
Other Criteria	For diagnosis of hepatic encephalopathy (HE): trial of, contraindication to, or medical reason for not using lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBSD): No more than 3 courses of 14 days each. For travelers diarrhea (TD) caused by noninvasive strains of E. Coli (with no bloody stools or fever): patient must be intolerant to or must have had a trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, allergist, immunologist, dermatologist, or otolaryngologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for moderate to severe persistent allergic asthma: 1) Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) Pretreatment serum IgE levels greater than 30 IU/mL, AND 3) Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus additional controller medication (ie. long-acting B2 agonist) for at least 3 months, or there is a medical reason for not using these drugs. Continuation of therapy or reauthorization criteria for moderate to severe persistent allergic asthma: 1) Reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, OR 2) Reduction of rescue inhaler use, OR 3) Documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). New starts for chronic idiopathic urticaria: 1) inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated), AND 2) disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria. Continuation of therapy or reauthorization criteria for chronic idiopathic urticaria: 1) improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use. New starts for nasal polyps: 1) currently using an intranasal corticosteroid, will be prescribed an intranasal corticosteroid with request,

PA Criteria	Criteria Details
	or has a medical reason for not using an intranasal corticosteroid. Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one. New starts for food allergy: 1) diagnosis of IgE-mediated food allergy 2) Xolair will be used in conjunction with food allergen avoidance.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

XYREM

Products Affected

- *sodium oxybate*
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist, pulmonologist, or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For somnolence associated with narcolepsy: trial of, contraindication to, or medical reason for not using a CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For cataplexy associated with narcolepsy, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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XYWAV

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist, pulmonologist or a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use a CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For the treatment of cataplexy associated with narcolepsy or idiopathic hypersomnia, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ZEPOSIA

Products Affected

- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For multiple sclerosis: Trial of, contraindication to, or medical reason for not using both dimethyl fumarate AND glatiramer or Glatopa. For ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication Humira or Hadlima or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ZILBRYSQ

Products Affected

- ZILBRYSQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, rheumatologist, or other appropriate specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient has tried and failed, a medical reason for not using, or has a contraindication to two (2) or more conventional therapies (i.e. pyridostigmine, corticosteroids, or non-steroidal immunosuppressive therapies)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
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	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ZURZUVAE

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented diagnosis of postpartum depression
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist or obstetrician/gynecologist
Coverage Duration	Request will be authorized until the end of the contract year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION — RECONSTITUTED 210 MG, 300 MG, 405 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral olanzapine without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using Abilify Maintena.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Part B Prerequisite	No

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PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- *amphotericin b intravenous solution reconstituted 50 mg*
- *amphotericin b liposome intravenous suspension reconstituted 50 mg*
- *aprepitant oral 80 & 125 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *clinisol sf intravenous solution 15 %*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- DIPHTHERIA-TETANUS TOXOIDS DT INTRAMUSCULAR SUSPENSION 25-5 LFU/0.5ML
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML
- ENGERIX-B INJECTION SUSPENSION 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- *formoterol fumarate inhalation nebulization solution 20 mcg/2ml*
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- *gengraf oral capsule 100 mg, 25 mg*
- *gengraf oral solution 100 mg/ml*
- *granisetron hcl oral tablet 1 mg*
- HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML
- IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*

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- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- *mycophenolic acid oral tablet delayed release 180 mg, 360 mg*
- NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- *plenamine intravenous solution 15 %*
- PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML
- RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- *sirolimus oral solution 1 mg/ml*
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)
- TETANUS-DIPHTHERIA TOXOIDS TD INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- *tobramycin inhalation nebulization solution 300 mg/5ml*

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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