ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ.
Indications	All FDA-approved Indications.
Off Label Uses	

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ.
Indications	All FDA-approved Indications.
Off Label Uses	

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ABIRATERONE

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FORMULARY PREFERRED AGENT ZYTIGA (ABIRATERONE ACETATE).
Indications	All FDA-approved Indications.
Off Label Uses	

ACALABRUTINIB

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ADALIMUMAB

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL FOR RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

AFATINIB DIMALEATE

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AGALSIDASE BETA

Products Affected

- FABRAZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING AN ALPHA-GAL A PHARMACOLOGICAL CHAPERONE (I.E. GALAFOLD (MIGALASTAT)). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
Age Restrictions	8 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALEMTUZUMAB - LEMTRADA

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: AT LEAST 12 MONTHS HAVE ELAPSED SINCE THE PATIENT RECEIVED THE MOST RECENT COURSE OF LEMTRADA.
Indications	All FDA-approved Indications.
Off Label Uses	

ALPELISIB

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMANTADINE

Products Affected

- GOCOVRI ORAL
  CAPSULE,EXTENDED RELEASE
  24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RHEUMATOID ARTHRITIS (RA) RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, RINVOQ, ENBREL, XELJANZ.
Indications	All FDA-approved Indications.
Off Label Uses	

APALUTAMIDE

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY.
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE - SL

Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE HCL

Products Affected

- APOKYN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF APOKYN.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PHYSICIAN ATTESTATION OF OPTIMIZATION OF DRUG THERAPY FOR PARKINSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA) PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID, ETC.)
Indications	All FDA-approved Indications.
Off Label Uses	

ASFOTASE

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-

PA Criteria	Criteria Details
	PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.
Indications	All FDA-approved Indications.
Off Label Uses	

ASPARAGINASE

Products Affected

- ONCASPAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ATEZOLIZUMAB

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVATROMBOPAG

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC LIVER DISEASE (CLD): PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	CLD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVELUMAB

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 7 YEARS OLD
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BARICITINIB

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ.
Indications	All FDA-approved Indications.
Off Label Uses	

BEDAQUILINE FUMARATE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

BELANTAMAB MAFODOTIN-BLMF

Products Affected

- BLENREP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BELIMUMAB

Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BELINOSTAT

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENDAMUSTINE

Products Affected

- BENDEKA
- TREANDA INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: CONCURRENT USE OF XOLAIR, DUPIXENT, OR OTHER ANTI-IL5 BIOLOGICS
Required Medical Information	INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, ORAL CORTICOSTEROID). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL: PATIENT HAS EXPERIENCED A REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN TOTAL DAILY DOSE OF ORAL CORTICOSTEROID FROM BASELINE IF THE PATIENT WAS ON MAINTENANCE ORAL CORTICOSTEROID THERAPY PRIOR TO INITIATION OF TREATMENT.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEXAROTENE

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BLINATUMOMAB

Products Affected

- BLINCYTO INTRAVENOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.
Other Criteria	INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA).

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

BORTEZOMIB

Products Affected

- BORTEZOMIB
- VELCADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BOSUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (PH+ CML): BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BRENTUXIMAB

Products Affected

- ADCETRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIGATINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRODALUMAB

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PATIENT HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CINRYZE RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

Products Affected

- HAEGARDA SUBCUTANEOUS
  RECON SOLN 2,000 UNIT, 3,000 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HAEGARDA RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB S-MALATE - CABOMETYX

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CANAKINUMAB

Products Affected

- ILARIS (PF) SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA), AND ADULT-ONSET STILL'S DISEASE (AOSD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	ADULT-ONSET STILL'S DISEASE (AOSD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUGS).
Indications	All FDA-approved Indications.
Off Label Uses	

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CLOBAZAM, TOPIRAMATE, LAMOTRIGINE.
Indications	All FDA-approved Indications.
Off Label Uses	

CANNABINOIDS

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.
Indications	All FDA-approved Indications.
Off Label Uses	

CAPLACIZUMAB YHDP

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	2 MONTHS
Other Criteria	CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).
Indications	All FDA-approved Indications.
Off Label Uses	

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CARFILZOMIB

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CEMIPLIMAB

Products Affected

- LIBTAYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CENOBAMATE

Products Affected

- XCOPRI MAINTENANCE PACK
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	TRIAL OF TWO GENERIC FORMULARY ANTICONVULSANT AGENTS INDICATED FOR PARTIAL-ONSET SEIZURES
Indications	All FDA-approved Indications.
Off Label Uses	

CERITINIB

Products Affected

- ZYKADIA ORAL CAPSULE
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT HAS ONE OF THE FOLLOWING OBJECTIVE SIGNS OF INFLAMMATION: 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA) PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION. TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	

COBIMETINIB FUMARATE

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COLCHICINE

Products Affected

- *colchicine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	

COPANLISIB DI-HCL

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CRIZANLIZUMAB-TMCA

Products Affected

- ADAKVEO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	SICKLE CELL DISEASE: INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PATIENT HAS ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 16 TO 17 YEARS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

CRIZOTINIB

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DABRAFENIB MESYLATE

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DACOMITINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	

DARATUMUMAB

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DARATUMUMAB-HYALURONIDASE-FIHJ

Products Affected

- DARZALEX FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DASATINIB

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.
Indications	All FDA-approved Indications.
Off Label Uses	

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- *deferasirox*
- JADENU SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER.
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERIPRONE

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF EXJADE, JADENU, OR DESFERAL AND ONE OF THE FOLLOWING CRITERIA 1) PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS OR HAS A CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION (I.E., CARDIAC T2 STAR MRI LESS THAN 10 MILLISECONDS, IRON INDUCED CARDIOMYOPATHY, FALL IN LEFT VENTRICULAR EJECTION FRACTION, ARRHYTHMIA INDICATING INADEQUATE CHELATION). RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

DEFEROXAMINE

Products Affected

- *deferoxamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	CHRONIC IRON OVERLOAD: AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	CHRONIC IRON OVERLOAD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

DEFLAZACORT

Products Affected

- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION).
Indications	All FDA-approved Indications.
Off Label Uses	

DELAFLOXACIN

Products Affected

- BAXDELA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH

PA Criteria	Criteria Details
Other Criteria	ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST OR ABSSSI ORGANISM ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE PREFERRED FORMULARY STANDARD OF CARE AGENT OR IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC. COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP, OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP.
Indications	All FDA-approved Indications.
Off Label Uses	

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEXTROMETHORPHAN QUINIDINE

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

DICHLORPHENAMIDE

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL REQUIRES PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

DICLOFENAC EPOLAMINE

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium topical gel 3 %*
- PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PENNSAID 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO FORMULARY DICLOFENAC SODIUM 1% TOPICAL GEL.
Indications	All FDA-approved Indications.
Off Label Uses	

DIMETHYL FUMARATE

Products Affected

- TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DINUTUXIMAB

Products Affected

- UNITUXIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DROXIDOPA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LYING FACE UP) POSITION.
Indications	All FDA-approved Indications.
Off Label Uses	

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL APPROVAL FOR EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ATOPIC DERMATITIS, CRSWNP: 6 MOS, ASTHMA: 12 MOS. RENEWAL: 12 MOS (ALL INDICATIONS).

PA Criteria	Criteria Details
Other Criteria	INITIAL APPROVAL FOR ATOPIC DERMATITIS REQUIRES: 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS, OR TOPICAL PDE4 INHIBITOR. 2) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS. 3) INTRACTABLE PRURITUS OR CRACKING/ OOZING/BLEEDING OF AFFECTED SKIN. INITIAL APPROVAL FOR ASTHMA: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, ORAL CORTICOSTEROID). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). INITIAL APPROVAL FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) PATIENT HAS INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY. RENEWAL FOR ATOPIC DERMATITIS AND CHRONIC RHINOSINUSITIS: PHYSICIAN ATTESTATION OF IMPROVEMENT. RENEWAL FOR ASTHMA: PATIENT HAS EXPERIENCED A REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN
	TOTAL DAILY DOSE OF ORAL CORTICOSTEROID FROM BASELINE IF THE PATIENT WAS ON MAINTENANCE ORAL CORTICOSTEROID THERAPY PRIOR TO INITIATION OF TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

DURVALUMAB

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EDARAVONE

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELAGOLIX SODIUM

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ONE OF THE FOLLOWING: 1) CONFIRMATORY GENETIC TEST OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA). PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: 1) THE PATIENT HAS FAILED OR IS NOT A CANDIDATE FOR HEMATOPOIETIC CELL TRANSPLANTATION (HCT) OR 2) REVCOVI WILL BE USED AS BRIDGING THERAPY PRIOR TO PLANNED HEMATOPOIETIC CELL TRANSPLANTATION (HCT) OR GENE THERAPY. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE AND THE PATIENT HAS NOT RECEIVED SUCCESSFUL HEMATOPOIETIC CELL TRANSPLANTATION (HCT) OR GENE THERAPY.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ELBASVIR/GRAZOPREVIR

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A -TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELIGLUSTAT TARTRATE

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELOSULFASE ALFA

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELOTUZUMAB

Products Affected

- EMPLICITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELTROMBOPAG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP: INITIAL: 2 MO. RENEW: 12 MO. HCV: 12 MO. SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLET FORMULATION. ITP: RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan* SUSPENSION
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. AMBRISENTAN: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). FORMULARY VERSION OF BOSENTAN: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ENFORTUMAB

Products Affected

- PADCEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENTRECTINIB

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENZALUTAMIDE

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF CASTRATION RESISTANT PROSTATE CANCER AND MEET ONE OF THE FOLLOWING: 1) METASTATIC CASTRATION RESISTANT PROSTATE CANCER, OR 2) NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS).
Indications	All FDA-approved Indications.
Off Label Uses	

EPOPROSTENOL IV

Products Affected

- *epoprostenol (glycine)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

EPTINEZUMAB-JJMR

Products Affected

- VYEPTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH, OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH VYEPTI THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

ERDAFITINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR
- AIMOVIG AUTOINJECTOR (2 PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.
Indications	All FDA-approved Indications.
Off Label Uses	

ERLOTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC KIDNEY DISEASE (CKD)/ ANEMIA RELATED TO ZIDOVUDINE THERAPY/ CANCER CHEMOTHERAPY: REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT AND MEETS ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: 12 MONTHS. SURGERY: 1 MONTH.

PA Criteria	Criteria Details
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

ERYTHROPOIESIS STIMULATING AGENTS - RETACRIT

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC KIDNEY DISEASE (CKD)/ ANEMIA RELATED TO ZIDOVUDINE THERAPY/ CANCER CHEMOTHERAPY: REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT AND MEETS ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: 12 MONTHS. SURGERY: 1 MONTH.

PA Criteria	Criteria Details
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

ESKETAMINE

Products Affected

- SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: TREATMENT-RESISTANT DEPRESSION (TRD): PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Age Restrictions	
Prescriber Restrictions	TRD: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	MDD: 12 MONTHS. TRD: INITIAL: 3 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRD: MEETS ALL OF THE FOLLOWING: 1) PATIENT HAS NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) PATIENT DOES NOT HAVE ACTIVE SUBSTANCE ABUSE, AND 3) PHYSICIAN ATTESTATION OF ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE.
Indications	All FDA-approved Indications.
Off Label Uses	

ETEPLIRSEN

Products Affected

- EXONDYS-51

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

EVEROLIMUS

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.
Indications	All FDA-approved Indications.
Off Label Uses	

FAM-TRASTUZUMAB

Products Affected

- ENHERTU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL NASAL SPRAY

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FILGRASTIM

Products Affected

- GRANIX
- NEUPOGEN
- NIVESTYM SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	A TRIAL OF OR CONTRAINDICATION TO ZARXIO IS REQUIRED EXCEPT WHEN USED TO INCREASE SURVIVAL IN A PATIENT ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION (HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME).
Indications	All FDA-approved Indications.
Off Label Uses	

FINGOLIMOD

Products Affected

- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FOSTAMATINIB

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FREMANEZUMAB-VFRM

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.
Indications	All FDA-approved Indications.
Off Label Uses	

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN 3)
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY. RENEWAL FOR EPISODIC CLUSTER HEADACHE: PHYSICIAN ATTESTATION OF IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINES: 6 MOS. CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL INDICATIONS): 12 MONTHS.
Other Criteria	INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL. CLUSTER HEADACHE: NO STEP.
Indications	All FDA-approved Indications.
Off Label Uses	

GEFITINIB

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GEMTUZUMAB OZOGAMICIN

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GIVOSIRAN

Products Affected

- GIVLAARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ACUTE HEPATIC PORPHYRIA (AHP): INITIAL: GENETIC CONFIRMATION OF MUTATION OR ELEVATED URINARY OR PLASMA PBG (PORPHOBILINOGEN) OR ALA (AMINOLEVULINIC ACID).
Age Restrictions	
Prescriber Restrictions	ACUTE HEPATIC PORPHYRIA (AHP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GENETICIST, HEPATOLOGIST, HEMATOLOGIST, GASTROENTEROLOGIST, NEUROLOGIST, DERMATOLOGIST, OR A HEALTHCARE PROVIDER EXPERIENCED IN MANAGING AHP.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	AHP: INITIAL: HAS EXPERIENCED TWO OR MORE ACUTE HEPATIC PORPHYRIA (AHP) ATTACKS IN THE PAST 12 MONTHS. RENEWAL: 1) HAS ACHIEVED OR MAINTAINED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED A LIVER TRANSPLANT.
Indications	All FDA-approved Indications.
Off Label Uses	

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLATIRAMER ACETATE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLECAPREVIR/PIBRENTASVIR

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

GLYCEROL PHENYLBUTYRATE

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL).
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB IV

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB SQ

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, OR ANKYLOSING SPONDYLITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

GUSELKUMAB

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PSO INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PSO: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSO: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

Products Affected

- *phenadoz*
- *promethazine injection solution*
- *promethazine oral*
- *promethazine rectal*
- *promethegan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE OR PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - SCOPOLAMINE

Products Affected

- *scopolamine base*
- TRANSDERM-SCOP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

Products Affected

- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

Products Affected

- *amabelz*
- *dotti*
- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch semiweekly*
- *estradiol transdermal patch weekly*
- *estradiol-norethindrone acet oral tablet 0.5-0.1 mg*
- *fyavolv*
- *jinteli*
- *mimvey*
- *mimvey lo*
- *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *methocarbamol oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY ANTICHOLINERGICS - CYPROHEPTADINE_CARBINOXAMINE

Products Affected

- *cyproheptadine oral syrup*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY- ANTICHOLINERGICS- DIPHENHYDRAMINE ELIXIR

Products Affected

- *diphenhydramine hcl oral elixir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ANTIHISTAMINIC CONDITIONS (PRURITUS OR URTICARIA): TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. INSOMNIA: TRIAL OF SILENOR AND BELSOMRA. MOTION SICKNESS AND ANTIPARKINSONISM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS AND ANAPHYLACTIC REACTIONS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY-DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY-INDOMETHACIN

Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY-MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY-PAROXETINE

Products Affected

- *paroxetine hcl oral tablet*
- PAXIL ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK MEDICATIONS IN THE ELDERLY-PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR TREATMENT OF EPILEPSY/SEIZURES IN PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: PATIENT HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYUREA

Products Affected

- SIKLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBRUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ICATIBANT

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

IDELALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IMATINIB MESYLATE

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GASTROINTESTINAL STROMAL TUMOR (GIST) TREATMENT: 36 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB

Products Affected

- REMICADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-ABDA

Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-AXXQ

Products Affected

- AVSOLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-DYYB

Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA FOR PATIENTS 18 YEARS OF AGE AND OLDER OR 2) PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 6 TO 17 YEARS OLD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA FOR PATIENTS 18 YEARS OF AGE AND OLDER.
Indications	All FDA-approved Indications.
Off Label Uses	

INOTUZUMAB OZOGAMICIN

Products Affected

- BESPONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERON ALFA-2B

Products Affected

- INTRON A INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
Coverage Duration	6 MONTHS.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA AND 24 MONTHS FOR HEPATITIS C. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERONS FOR MS-BETASERON, EXTAVIA

Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: AUBAGIO, AVONEX, PLEGRIDY, REBIF, TECFIDERA, GLATIRAMER/COPAXONE/GLATOPA, VUMERITY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	NSCLC: PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4 MO, RCC/CRC/HCC: 3 MO, NSCLC: 12 MO, CUTAN MEL: INITIAL/RENEWAL: 6 MO
Other Criteria	RENEWAL FOR ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)
Indications	All FDA-approved Indications.
Off Label Uses	

ISATUXIMAB-IRFC

Products Affected

- SARCLISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IXAZOMIB

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IXEKIZUMAB

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS WHERE AGES ALIGN: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, XELJANZ. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, COSENTYX. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FOLLOWING PREFERRED AGENT: COSENTYX.
Indications	All FDA-approved Indications.
Off Label Uses	

LANADELUMAB

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

LANREOTIDE ACETATE

Products Affected

- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LAPATINIB DITOSYLATE

Products Affected

- TYKERB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LAROTRECTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	APPROVAL FOR VITRAKVI ORAL SOLUTION REQUIRES TRIAL OF VITRAKVI CAPSULES OR PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE CAPSULE FORMULATION.
Indications	All FDA-approved Indications.
Off Label Uses	

LASMIDITAN

Products Affected

- REYVOW ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTAN. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT AS DEFINED BY ONE OF THE FOLLOWING: 1) ABILITY TO FUNCTION NORMALLY WITHIN 2 HOURS OF DOSE, 2) HEADACHE PAIN DISAPPEARS WITHIN 2 HOURS OF DOSE, 3) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/RITONAVIR. REQUESTS FOR GENERIC LEDIPASVIR/SOFOSBUVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND HARVONI.
Indications	All FDA-approved Indications.
Off Label Uses	

LENALIDOMIDE

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LENVATINIB MESYLATE

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LETERMOVIR

Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEVODOPA

Products Affected

- INBRIJA 42 MG INHALATION CAP
- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF INBRIJA.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT IS NOT CURRENTLY TAKING MORE THAN 1600MG OF LEVODOPA PER DAY. PHYSICIAN ATTESTATION OF OPTIMIZATION OF DRUG THERAPY FOR PARKINSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

L-GLUTAMINE

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
Other Criteria	INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 5-17 WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: PHYSICIAN ATTESTATION PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE TIRF

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocaine topical ointment*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PATCH: 12 MONTHS. OINTMENT: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

LOMITAPIDE

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).
Indications	All FDA-approved Indications.
Off Label Uses	

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

LURBINECTEDIN

Products Affected

- ZEPZELCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUSUTROMBOPAG

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PLANNED PROCEDURE 8 TO 14 DAYS AFTER INITIATION OF MULPLETA. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. AVATROMBOPAG, ROMIPLOSTIM, ELTROMBOPAG).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	1 MONTH
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEPOLIZUMAB

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: ASTHMA: PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G. LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, ORAL CORTICOSTEROID). THE PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS). RENEWAL: ASTHMA: PATIENT HAS EXPERIENCED A REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN TOTAL DAILY DOSE OF ORAL CORTICOSTEROID FROM BASELINE IF THE PATIENT WAS ON MAINTENANCE ORAL CORTICOSTEROID THERAPY PRIOR TO INITIATION OF TREATMENT.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

METHYLNALTREXONE

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC, NON-CANCER PAIN.
Other Criteria	ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).
Indications	All FDA-approved Indications.
Off Label Uses	

METHYLNALTREXONE ORAL

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).
Indications	All FDA-approved Indications.
Off Label Uses	

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MIFEPRISTONE

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MIGALASTAT HCL

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MOS. RENEWAL: 12 MOS
Other Criteria	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.
Indications	All FDA-approved Indications.
Off Label Uses	

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MOXETUMOMAB PASUDOTOX

Products Affected

- LUMOXITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	PATIENT HAS NOT PREVIOUSLY RECEIVED 6 CYCLES OF LUMOXITI
Indications	All FDA-approved Indications.
Off Label Uses	

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

NATALIZUMAB

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MOS. CROHN'S DISEASE: INITIAL:6 MOS. RENEWAL: 12 MOS.
Other Criteria	MULTIPLE SCLEROSIS (MS) INITIAL CRITERIA: PREVIOUS TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF MS. CROHN'S DISEASE INITIAL CRITERIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. CROHN'S DISEASE RENEWAL CRITERIA: PATIENT HAS RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHN'S DISEASE WHILE ON TYSABRI, OR PATIENT HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

NECITUMUMAB

Products Affected

- PORTRAZZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NERATINIB MALEATE

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE TUMOR (STAGE I-III) AND TUMOR IS HORMONE-RECEPTOR POSITIVE AND THE MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE
Indications	All FDA-approved Indications.
Off Label Uses	

NILOTINIB

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, AND F359V/C/I.
Indications	All FDA-approved Indications.
Off Label Uses	

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	IDIOPATHIC PULMONARY FIBROSIS (IPF): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF PATIENT DOES NOT HAVE A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50 PERCENT OR HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	IDIOPATHIC PULMONARY FIBROSIS (IPF): A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASES WITH A PROGRESSIVE PHENOTYPE (PF-ILD): INITIAL: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 45% OF PREDICTED VALUE. SSC-ILD: NO EXTRA CRITERIA.
Age Restrictions	INITIAL: PF-ILD: 18 YEARS OR OLDER
Prescriber Restrictions	IPF: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST. PF-ILD: INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST. SSC-ILD: NO EXTRA CRITERIA.
Coverage Duration	PF-ILD: INITIAL AND RENEWAL: 12 MONTHS. IPF AND SSC-ILD: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	PF-ILD: INITIAL: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE) RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	

NIRAPARIB TOSYLATE

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NITISINONE

Products Affected

- *nitisinone*
- NITYR
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE 1 AS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED FORMULARY NITISINONE TABLETS OR CAPSULES. RENEWAL: THE PATIENT'S URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Indications	All FDA-approved Indications.
Off Label Uses	

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	NSCLC IN COMBINATION WITH YERVOY (IPILIMUMAB): PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.
Indications	All FDA-approved Indications.
Off Label Uses	

OBETICHOLIC ACID

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
Required Medical Information	DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AS CONFIRMED BY AT LEAST TWO OF THE FOLLOWING CRITERIA: AN ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), THE PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: PATIENT'S ALKALINE PHOSPHATASE LEVELS ARE LESS THAN 1.67-TIMES THE UPPER LIMIT OF NORMAL OR HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OBETICHOLIC ACID.
Indications	All FDA-approved Indications.
Off Label Uses	

OBINUTUZUMAB

Products Affected

- GAZYVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): THE PATIENT HAD A PREVIOUS TRIAL OF TWO AGENTS INDICATED FOR TREATMENT OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval

OMACETAXINE

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS.
Other Criteria	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENT'S HEMATOLOGIC RESPONSE, DEFINED AS (1) AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR (2) THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.
Indications	All FDA-approved Indications.
Off Label Uses	

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF DUPIXENT OR ANTI-IL5 BIOLOGIC.
Required Medical Information	INITIAL APPROVAL FOR ASTHMA: POSITIVE SKIN PRICK OR RAST TEST TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC IDIOPATHIC URTICARIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL: ASTHMA: 12 MOS. CHRONIC IDIOPATHIC URTICARIA: 6 MOS. ALL RENEWAL: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL APPROVAL FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND PATIENT STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. INITIAL APPROVAL FOR ASTHMA: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, ORAL CORTICOSTEROID). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). 3) XOLAIR WILL BE USED AS ADD-ON MAINTENANCE TREATMENT. RENEWAL FOR ASTHMA: PATIENT HAS EXPERIENCED A REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN TOTAL DAILY DOSE OF ORAL CORTICOSTEROID FROM BASELINE IF THE PATIENT WAS ON MAINTENANCE ORAL CORTICOSTEROID THERAPY PRIOR TO INITIATION OF TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

OMBITASVIR-PARITAPREVIR-RITONAVIR

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Exclusion Criteria	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. MUST BE USED CONCURRENTLY WITH RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED THREE TIMES DAILY FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.
Indications	All FDA-approved Indications.
Off Label Uses	

OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Exclusion Criteria	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHN'S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL
Indications	All FDA-approved Indications.
Off Label Uses	

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	METASTATIC NSCLC WITH EGFR T790M MUTATION: CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OXYMETHOLONE

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OZANIMOD

Products Affected

- ZEPOSIA
- ZEPOSIA STARTER KIT
- ZEPOSIA STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF ONE SPHINGOSINE-1-PHOSPHATE RECEPTOR MODULATOR (E.G. GILENYA, MAYZENT) AND ANY ONE AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS
Indications	All FDA-approved Indications.
Off Label Uses	

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PALIVIZUMAB

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	GESTATIONAL AGE
Age Restrictions	LESS THAN 24 MONTHS OF AGE.
Prescriber Restrictions	
Coverage Duration	1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY SYNCYTIAL VIRUS INFECTIONS. INITIAL: APPROVAL WILL BE FOR AT LEAST 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON. RENEWAL: ADDITIONAL 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.
Indications	All FDA-approved Indications.
Off Label Uses	

PANOBINOSTAT

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.
Indications	All FDA-approved Indications.
Off Label Uses	

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PAZOPANIB

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

- *alyq*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

Products Affected

- *sildenafil (pulm.hypertension) intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

PEGFILGRASTIM

Products Affected

- FULPHILA
- NEULASTA SUBCUTANEOUS SYRINGE
- UDENYCA
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	REQUESTS FOR NEULASTA REQUIRE THAT THE PATIENT HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO FULPHILA OR UDENYCA WHERE INDICATIONS ALIGN. REQUESTS FOR NEULASTA ONPRO REQUIRE THAT THE PATIENT HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO FULPHILA OR UDENYCA WHERE INDICATIONS ALIGN OR PHYSICIAN ATTESTATION THAT THE PATIENT HAS A BARRIER TO ACCESS (E.G., TRAVEL BARRIERS, THE PATIENT IS UNABLE TO RETURN TO THE CLINIC FOR THEIR NEULASTA INJECTION). REQUESTS FOR ZIEXTENZO REQUIRE THAT THE PATIENT HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO FULPHILA OR UDENYCA WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	

PEG-INTERFERON ALFA-2B-SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	OVERALL DURATION OF THERAPY LIMITED TO 5 YEARS.
Indications	All FDA-approved Indications.
Off Label Uses	

PEGVALIASE-PQPZ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: REDUCTION IN PHENYLALANINE LEVELS BY AT LEAST 20 PERCENT FROM BASELINE OR TO A LEVEL UNDER 600 MICROMOLES PER LITER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEGVISOMANT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PENICILLAMINE

Products Affected

- *penicillamine*
- THIOLA EC

PA Criteria	Criteria Details
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	INITIAL WILSON'S DISEASE: KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COOPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL FOR ALL INDICATIONS: 12 MONTHS. RENEWAL FOR WILSON'S DISEASE: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	RHEUMATOID ARTHRITIS/WILSON'S DISEASE: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) OR THIOLA/THIOLA EC. RENEWAL WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

PERTUZUMAB-TRASTUZUMAB-HY-ZZXF

Products Affected

- PHESGO SUBCUTANEOUS SOLUTION 1,200 MG-600MG- 30000 UNIT/15ML, 600 MG-600 MG- 20000 UNIT/10ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEXIDARTINIB

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).
Coverage Duration	INITIAL 12 MONTHS. RENEWAL 12 MONTHS.
Other Criteria	RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

PIRFENIDONE

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50%.
Indications	All FDA-approved Indications.
Off Label Uses	

POLATUZUMAB VEDOTIN

Products Affected

- POLIVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PONATINIB

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PRAMLINTIDE

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS.
Other Criteria	RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	

RAMUCIRUMAB

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: CONCURRENT USE OF XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, ORAL CORTICOSTEROID). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL: PATIENT HAS EXPERIENCED A REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN TOTAL DAILY DOSE OF ORAL CORTICOSTEROID FROM BASELINE IF THE PATIENT WAS ON MAINTENANCE ORAL CORTICOSTEROID THERAPY PRIOR TO INITIATION OF TREATMENT.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

RIBOCICLIB

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	REQUIRES A TRIAL OF OR CONTRAINDICATION TO VERZENIO OR IBRANCE WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS' DIARRHEA/HEPATIC ENCEPHALOPATHY: 12 MOS. IBS-D: 12 WKS.
Other Criteria	FOR RIFAXIMIN 550 MG TABLETS ONLY: HEPATIC ENCEPHALOPATHY (HE): PREVIOUS TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTAN. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT AS DEFINED BY ONE OF THE FOLLOWING: 1) ABILITY TO FUNCTION NORMALLY WITHIN 2 HOURS OF DOSE, 2) HEADACHE PAIN DISAPPEARS WITHIN 2 HOURS OF DOSE, OR 3) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL FOR PAH: PATIENT IS NOT CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS (E.G. AMYL NITRATE), PHOSPHODIESTERASE INHIBITORS (E.G. SILDENAFIL, TADALAFIL, OR VARDENAFIL), OR NON-SPECIFIC PDE INHIBITORS (E.G. DIPYRIDAMOLE, THEOPHYLLINE). INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH. PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS OR ANY PDE INHIBITORS (E.G.VIAGRA, CIALIS, DIPYRIDAMOLE).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. DIAGNOSIS OF PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL FOR PAH: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR, SUCH AS REVATIO (SILDENAFIL) OR ADCIRCA (TADALAFIL). RENEWAL FOR PAH AND CTEPH: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI SUBCUTANEOUS SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE
Indications	All FDA-approved Indications.
Off Label Uses	

RISDIPLAM

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROMUSCULAR SPECIALIST OR SPINAL MUSCULAR ATROPHY (SMA) SPECIALIST AT A SMA SPECIALTY CENTER.
Coverage Duration	SMA: INITIAL/RENEWAL: 12 MONTHS
Other Criteria	SPINAL MUSCULAR ATROPHY (SMA): INITIAL: DOCUMENTATION OF GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: DOCUMENTATION OF UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING. FOR SYMPTOMATIC PATIENTS: 1) ONSET OF SMA SYMPTOMS OCCURRED BEFORE 20 YEARS OF AGE, 2) DOCUMENTATION OF BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, 3) IF PREVIOUSLY RECEIVED GENE THERAPY, THE PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR OTHER MUSCLE FUNCTION.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB

Products Affected

- RITUXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO. RENEWAL: 12 MONTHS. NHL, PV: 12 MONTHS. CLL: 6 MO. WG, MPA: 3 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THE PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO. RENEWAL: 12 MONTHS. NHL: 12 MONTHS. CLL: 6 MONTHS. WG, MPA: 3 MONTHS
Other Criteria	RHEUMATOID ARTHRITIS (RA): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. RENEWAL: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB-PVVR

Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NHL, CLL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	NHL: 12 MONTHS. CLL: 6 MONTHS. WG, MPA: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

ROMOSOZUMAB

Products Affected

- EVENITY 105 MG/1.17 ML SYRINGE
- EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG, OR SERUM TESTOSTERONE LEVEL LESS THAN 50 NG/DL.
Indications	All FDA-approved Indications.
Off Label Uses	

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYELOFIBROSIS RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY. ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD): NO RENEWAL CRITERIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SACITUZUMAB

Products Affected

- TRODELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SAFINAMIDE MESYLATE

Products Affected

- XADAGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ.
Indications	All FDA-approved Indications.
Off Label Uses	

SEBELIPASE ALFA

Products Affected

- KANUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.
Coverage Duration	LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY, AS CONFIRMED BY THE PRESENCE OF CLINICAL FEATURES (E.G., HEPATOMEGALY, ELEVATED SERUM TRANSAMINASES, DYSLIPIDEMIA, SPLENOMEGALY) PLUS ANY OF THE FOLLOWING: A BLOOD TEST INDICATING LOW OR ABSENT LEVELS OF LAL ENZYME ACTIVITY, A DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LAL ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE BI-ALLELIC PRESENCE OF ALTERED LIPA GENE(S). RENEWAL:DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE REQUIRES DOCUMENTED IMPROVEMENT IN ANY ONE OF THE FOLLOWING CLINICAL PARAMETERS ASSOCIATED WITH LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY DURING THE PAST 6 MONTHS: A RELATIVE REDUCTION FROM BASELINE IN ANY ONE OF THE FOLLOWING LIPID LEVELS (LDL-C, NON-HDL-C, OR TRIGLYCERIDES), NORMALIZATION OF ASPARTATE AMINOTRANSFERASE (AST) BASED ON AGE- AND GENDER-SPECIFIC NORMAL RANGES, A DECREASE IN LIVER FAT CONTENT COMPARED TO BASELINE ASSESSED BY ABDOMINAL IMAGING (E.G., MULTI-ECHO GRADIENT ECHO [MEGE] MRI). DIAGNOSIS OF RAPIDLY PROGRESSIVE LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING WITHIN THE FIRST 6 MONTHS OF LIFE: 12 MONTHS. A DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE: INITIAL: 6 MONTHS
Indications	All FDA-approved Indications.
Off Label Uses	

SECUKINUMAB

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG).
Indications	All FDA-approved Indications.
Off Label Uses	

SELEXIPAG

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG PACK
- UPTRAVI ORAL TABLETS,DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SELPERCATINIB

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SILTUXIMAB

Products Affected

- SYLVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SODIUM OXYBATE

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH ONE OF THE FOLLOWING SPECIALISTS: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: ALL INDICATIONS: THIS MEDICATION WILL NOT BE APPROVED FOR PATIENTS CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS. EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED OR HAS A CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. RENEWAL: PHYSICIAN ATTESTATION OF SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOFOSBUVIR

Products Affected

- SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG
- SOVALDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.
Indications	All FDA-approved Indications.
Off Label Uses	

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. REQUESTS FOR GENERIC SOFOSBUVIR/VELPATASVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND EPCLUSA.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.
Indications	All FDA-approved Indications.
Off Label Uses	

SOLRIAMFETOL

Products Affected

- SUNOSI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. OBSTRUCTIVE SLEEP APNEA (OSA): THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL. RENEWAL: PHYSICIAN ATTESTATION OF SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN - GROWTH HORMONE

Products Affected

- HUMATROPE
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- ZOMACTON

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND SHOX DEFICIENCY.
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT SHOX DEFICIENCY: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	3 MONTHS
Other Criteria	INITIAL: HIV/WASTING: PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. RENEWAL: HIV/WASTING: PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: HIV/WASTING: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN - ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST
Coverage Duration	SHORT BOWEL: 4 WEEKS ONCE.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN-NORDITROPIN AND GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND NOONAN SYNDROME.
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN-NUTROPIN AND NUTROPIN AQ

Products Affected

- NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), AND TURNER SYNDROME (TS).
Required Medical Information	INITIAL FOR PEDIATRIC GHD, ISS, AND TS: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. INITIAL FOR CKD: HEIGHT OR GROWTH VELOCITY AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CKD: NEPHROLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT CKD: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR ALL INDICATIONS EXCEPT ADULT GHD: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SORAFENIB TOSYLATE

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SUNITINIB MALATE

Products Affected

- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.
Indications	All FDA-approved Indications.
Off Label Uses	

TAFAMIDIS

Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.
Indications	All FDA-approved Indications.
Off Label Uses	

TAFASITAMAB-CXIX

Products Affected

- MONJUVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TALAZOPARIB

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

TALIMOGENE

Products Affected

- IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML, 10EXP8 (100 MILLION) PFU/ML

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS. PATIENT IS NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE. NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

TASIMELTEON

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TAZEMETOSTAT

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TEDUGLUTIDE

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK
Indications	All FDA-approved Indications.
Off Label Uses	

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TEMOZOLOMIDE

Products Affected

- TEMODAR INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TEPROTUMUMAB-TRBW

Products Affected

- TEPEZZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TERIFLUNOMIDE

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TERIPARATIDE

Products Affected

- FORTEO
- *teriparatide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

TESAMORELIN

Products Affected

- EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG
- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE

Products Affected

- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)*
- *testosterone transdermal solution in metered pump w/app*
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MALE HYPOGONADISM: INITIAL: CONFIRMED BY EITHER: 1) AT LEAST TWO MORNING TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS WHILE IN A FASTED STATE OR 2) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PRIMARY OR SECONDARY HYPOGONADISM: 12 MONTHS. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.
Other Criteria	MALE HYPOGONADISM: INITIAL: NO TESTOSTERONE LEVELS ARE REQUIRED WHEN THERE IS A PREVIOUSLY APPROVED AUTHORIZATION FOR TESTOSTERONE OR PATIENT HAS RECEIVED ANY FORM OF TESTOSTERONE REPLACEMENT THERAPY PER PHYSICIAN ATTESTATION OR CLAIMS HISTORY. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TILDRAKIZUMAB

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI.
Indications	All FDA-approved Indications.
Off Label Uses	

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA, PJIA, OR SJIA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	MODERATE TO SEVERE RHEUMATOID ARTHRITIS (RA), AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, OR SJIA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: 12 MONTHS FOR RA, PJIA, OR SJIA
Other Criteria	INITIAL: RA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PJIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.
Indications	All FDA-approved Indications.
Off Label Uses	

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RA, PJIA, AND SJIA RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. PJIA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.
Indications	All FDA-approved Indications.
Off Label Uses	

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE , MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).
Indications	All FDA-approved Indications.
Off Label Uses	

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	

TRABECTEDIN

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRAMETINIB DIMETHYL SULFOXIDE

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB

Products Affected

- HERCEPTIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB HYALURONIDASE

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-ANNS

Products Affected

- KANJINTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-DTTB

Products Affected

- ONTRUZANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-PKRB

Products Affected

- HERZUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-QYYP

Products Affected

- TRAZIMERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TREPROSTINIL DIOLAMINE

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT.
Required Medical Information	CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. TRIAL OF OR CONTRAINDICATION TO A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR AN ENDOTHELIN RECEPTOR ANTAGONIST. TRIAL OF A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

TREPROSTINIL INHALED

Products Affected

- TYVASO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	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. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

TREPROSTINIL SODIUM INJECTABLE

Products Affected

- *treprostinil sodium*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. CONTINUATION OF CURRENT REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC II-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC III-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY FOR PATIENTS WITH NYHA/WHO FC II SYMPTOMS REQUIRES A TRIAL OF OR CONTRAINDICATION TO A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR AN ENDOTHELIN RECEPTOR ANTAGONIST. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

TRIENTINE

Products Affected

- *clovique*
- *trientine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE (DEPEN). RENEWAL: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTAN. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT AS DEFINED BY ONE OF THE FOLLOWING: 1) ABILITY TO FUNCTION NORMALLY WITHIN 2 HOURS OF DOSE, 2) HEADACHE PAIN DISAPPEARS WITHIN 2 HOURS OF DOSE, 3) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	

UPADACITINIB

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RHEUMATOID ARTHRITIS (RA): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

URIDINE TRIACETATE

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

USTEKINUMAB

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA OR FACE. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE AND ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD, UC: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD) AND ULCERATIVE COLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

USTEKINUMAB IV

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

VALBENAZINE TOSYLATE

Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PRIOR HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA PER PHYSICIAN ATTESTATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VESTRONIDASE ALFA VJBK

Products Affected

- MEPSEVII

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS IMPROVED, MAINTAINED, OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY FROM BASELINE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN GENETIC OR METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING CRITERIA: 1) THE PATIENT HAS NOT UNDERGONE SUCCESSFUL BONE MARROW OR STEM CELL TREATMENT FOR MPS VII, 2) THE PATIENT HAS LIMITATION IN MOBILITY, BUT REMAINS SUFFICIENTLY AMBUATLORY, AND 3) DIAGNOSIS OF MPS VII CONFIRMED BY ALL OF THE FOLLOWING CRITERIA: A) PHYSICIAN ATTESTATION OF URINARY GAG (GLYCOSAMINOGLYCAN) LEVEL OF GREATER THAN THREE TIMES THE UPPER LEVEL OF NORMAL BASED ON THE LABORATORY ASSAY, B) PHYSICIAN ATTESTATION OF BETA-GLUCURONIDASE ENZYME ACTIVITY DEFICIENCY OR GENETIC TESTING, AND C) PHYSICIAN ATTESTATION THAT THE PATIENT HAS AT LEAST ONE OF THE FOLLOWING CLINICAL SIGNS OF MPS VII: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTIONS OR PULMONARY DYSFUNCTION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

VIGABATRIN

Products Affected

- SABRIL ORAL TABLET
- *vigabatrin*
- *vigadrone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS): PATIENT HAS RESPONDED INADEQUATELY TO AT LEAST 2 ANTIEPILEPTIC AGENTS. FOR CPS AND INFANTILE SPASMS: PHYSICIAN ATTESTATION THAT BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS.
Indications	All FDA-approved Indications.
Off Label Uses	

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZANUBRUTINIB

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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