

## ABIRATERONE

### Products Affected

- Abiraterone Acetate

- Abirtega

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer, very-high-risk prostate cancer, non-metastatic high-risk prostate cancer, non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence/recurrence after radical prostatectomy
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ACITRETIN

---

## Products Affected

- Acitretin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)
Exclusion Criteria	N/A
Required Medical Information	For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate or cyclosporine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ACTIMMUNE

---

## Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides, Sezary syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# AIMOVIG

---

## Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

# AKEEGA

---

## Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ALECENSA

## Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large-cell lymphoma (ALCL), Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumors (IMT) with ALK translocation, ALK-positive large B-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic OR 2) the requested drug will be used as adjuvant treatment following tumor resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ALOSETRON

## Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate treatment response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ALPHA1-PROTEINASE INHIBITOR

## Products Affected

- Prolastin-c

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha 1-proteinase inhibitor level less than 11 micromol/L (80 milligrams per deciliter [mg/dL] by radial immunodiffusion or 50 mg/dL by nephelometry).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# ALUNBRIG

## Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, inflammatory myofibroblastic tumors (IMT) with ALK translocation, Erdheim-Chester disease (ECD) with ALK-fusion
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ALVAIZ

## Products Affected

- Alvaiz

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): the requested drug is used for initiation and maintenance of interferon-based therapy. For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): Pt had an insufficient response to immunosuppressive therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks

<b>Other Criteria</b>	<p>For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).</p>
-----------------------	--

# AMBRISENTAN

---

## Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ARCALYST

## Products Affected

- Arcalyst

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Prevention of gout flares in patients initiating or continuing urate-lowering therapy
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance, or contraindication to maximum tolerated doses of a NSAID and colchicine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ARIKAYCE

---

## Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ARMODAFINIL

---

## Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ASPARLAS

---

## Products Affected

- Asparlas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	21 years of age or younger
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# AUBAGIO

---

## Products Affected

- Teriflunomide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# AUGTYRO

---

## Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# AUSTEDO

---

## Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tourette's syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# AUVELITY

---

## Products Affected

- Auvelity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# AYVAKIT

## Products Affected

- Ayvakit

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842V mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including a PDGFRA D842V mutation, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in residual, unresectable, tumor rupture, or recurrent/metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# BAFIERTAM

---

## Products Affected

- Bafiertam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BALVERSA

## Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) genetic alterations, AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced, recurrent, or metastatic urothelial carcinoma, OR b) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BANZEL

---

## Products Affected

- Rufinamide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# BENLYSTA

## Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	For patients new to therapy: severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) patient is currently receiving a stable standard therapy regimen for SLE (for example, corticosteroid, antimalarial, or NSAIDs), OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE. For lupus nephritis: 1) patient is currently receiving a stable standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BERINERT

## Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

# BESREMI

---

## Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BETASERON

---

## Products Affected

- Betaseron

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BEXAROTENE

## Products Affected

- Bexarotene CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS), CD30-positive primary cutaneous anaplastic large cell lymphoma (ALCL), CD30-positive lymphomatoid papulosis (LyP)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BOSENTAN

## Products Affected

- Bosentan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) if the request is for an adult patient, the patient meets both of the following: a) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units, and b) the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ambrisentan (Letairis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BOSULIF

## Products Affected

- Bosulif

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) Patient has experienced resistance or intolerance to imatinib, dasatinib, or nilotinib. For B-ALL including patients who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# BRAFTOVI

## Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Adjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma, recurrent NSCLC
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The patient has either of the following: a) advanced or metastatic disease, b) unresectable metachronous metastases. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For non-small cell lung cancer (NSCLC): 1) Tumor is positive for BRAF V600E mutation, AND 2) Disease is advanced, recurrent, or metastatic, AND 3) The requested drug will be used in combination with binimetinib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A



# BRIVIACT

## Products Affected

- Briviact ORAL SOLN
- Briviact TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BRIVIACT INJ

## Products Affected

- Briviact INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BRONCHITOL

---

## Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BRUKINSA

## Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mantle cell lymphoma and chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): the patient has experienced an intolerable adverse event or has a contraindication to Calquence (acalabrutinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BUPRENORPHINE

## Products Affected

- Buprenorphine Hcl SUBL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for the treatment of opioid use disorder AND patient meets one of the following: 1) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 2) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 3) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# BUPRENORPHINE PATCH

## Products Affected

- Buprenorphine PTWK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CABOMETYX

## Products Affected

- Cabometyx

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV (including brain metastases). For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent therapy. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, oncocyctic): 1) the disease is locally advanced or metastatic, AND 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI. For endometrial carcinoma: 1) the disease is recurrent, AND 2) the requested drug will be used as subsequent therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# CALCIPOTRIENE

## Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN
- Calcitrene
- Calcitriol OINT

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# CALQUENCE

## Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	N/A
Required Medical Information	For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CAPRELSA

## Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinomas (follicular, oncocytic, papillary).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CARAC

## Products Affected

- Fluorouracil CREA 0.5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who are pregnant or may become pregnant. Patients with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	If being used as part of a compounded product, all active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

# CARBAGLU

---

## Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CAYSTON

---

## Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CERDELGA

## Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CHANTIX AET

---

## Products Affected

- Varenicline Starting Month
- Varenicline Tartrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	This Prior Authorization requirement applies after the patient has received a cumulative 24 weeks of therapy in a Plan Year.

## CHLORDIAZEPOXIDE - 65

### Products Affected

- Chlordiazepoxide Hcl CAPS 10MG, 5MG
- Chlordiazepoxide Hydrochloride CAPS 25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: the prescriber must acknowledge the benefit of therapy with the prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) the requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), or b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-preop apprehens and anx-1 mo, Anxiety Disorder-4 mo, Alc Withdrawal-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.



# CLOBAZAM

---

## Products Affected

- Clobazam SUSP 2.5MG/ML
- Clobazam TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CLOMIPRAMINE

## Products Affected

- Clomipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Depression, panic disorder
Exclusion Criteria	N/A
Required Medical Information	For obsessive-compulsive disorder (OCD) and panic disorder: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI). For depression: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CLORAZEPATE

## Products Affected

- Clorazepate Dipotassium TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

# CLOZAPINE ODT

---

## Products Affected

- Clozapine Odt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# COBENFY

## Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# COLY-MYCIN

## Products Affected

- Colistimethate Sodium INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being used intravenously (IV) or intramuscularly (IM). Administration will not be via nebulizer (Note: CMS endorsed compendia do not support inhalation/nebulization of colistimethate.). The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Initial approval: 3 months. Renewal: Plan Year
Other Criteria	N/A

# COMETRIQ

---

## Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-small cell lung cancer (NSCLC), thyroid carcinomas (follicular, oncocytic, papillary).
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): Disease is positive for rearranged during transfection (RET) rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# COPIKTRA

## Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# COSENTYX

## Products Affected

- Cosentyx

- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, scalp, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Pyzchiva (ustekinumab-ttwe), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce). For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): patient meets any of the following: 1) patient has experienced an inadequate treatment response to a non-steroidal anti-inflammatory drug (NSAID) OR 2) patient has experienced an intolerance or has a contraindication to NSAIDs. For an adult with active psoriatic arthritis (PsA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Pyzchiva (ustekinumab-ttwe), Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release), Yesintek (ustekinumab-kfce).
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For moderate to severe hidradenitis suppurativa (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf).

# COTELLIC

## Products Affected

- Cotellic

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Central nervous system (CNS) cancer (i.e., glioma, glioblastoma), adjuvant systemic therapy for cutaneous melanoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For central nervous system (CNS) cancer (i.e., glioma, glioblastoma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# CYCLOPHOSPHAMIDE ORAL

## Products Affected

- Cyclophosphamide CAPS
- Cyclophosphamide TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# CYSTAGON

## Products Affected

- Cystagon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# CYSTARAN

## Products Affected

- Cystaran

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DALFAMPRIDINE

## Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For multiple sclerosis, patient must meet the following (for new starts): prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis (continuation): patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DANZITEN

## Products Affected

- Danziten

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), pigmented villonodular synovitis/tenosynovial giant cell tumor
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A



# DARAPRIM

## Products Affected

- Pyrimethamine TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia prophylaxis, cystoisosporiasis treatment and secondary prophylaxis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For primary toxoplasmosis prophylaxis and Pneumocystis jirovecii pneumonia (PCP) prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) AND 2) The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 3 months. For secondary toxoplasmosis prophylaxis: The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 6 months. For cystoisosporiasis treatment: The patient has experienced an intolerance or has a contraindication to TMP-SMX. For secondary cystoisosporiasis prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to TMP-SMX AND 2) The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 6 months.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Congen toxo tx: Plan Yr. Acqu toxo tx, prim toxo ppx, PCP ppx: 3mo. Sec toxo ppx, cysto tx/ppx: 6mo
<b>Other Criteria</b>	N/A

# DAURISMO

## Products Affected

- Daurismo

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Post-induction therapy/consolidation following response to previous therapy with the same regimen for acute myeloid leukemia (AML), relapsed/refractory AML as a component of repeating the initial successful induction regimen
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For acute myeloid leukemia (AML): 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy, post-induction/consolidation therapy, or relapsed or refractory disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# DEFERASIROX

---

## Products Affected

- Deferasirox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DEMSEER

---

## Products Affected

- Metyrosine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DHE NASAL

## Products Affected

- Dihydroergotamine Mesylate NASAL SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one triptan 5-HT <sub>1</sub> receptor agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DIACOMIT

---

## Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# DIAZEPAM AET

## Products Affected

- Diazepam CONC
- Diazepam INJ 5MG/ML
- Diazepam SOLN 5MG/5ML
- Diazepam TABS
- Diazepam Intensol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

# DRIZALMA

---

## Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cancer pain, chemotherapy-induced neuropathic pain
Exclusion Criteria	N/A
Required Medical Information	1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration).
Age Restrictions	Generalized Anxiety Disorder: 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# DRONABINOL

## Products Affected

- Dronabinol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nausea and vomiting associated with cancer chemotherapy: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one oral 5-HT3 receptor antagonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# DUPIXENT

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: Patient achieved or maintained positive clinical response. For oral corticosteroid dependent asthma, initial therapy: Patient has inadequate asthma control despite current treatment with both of the following medications: 1) High-dose inhaled corticosteroid AND 2) Additional controller (i.e., long acting beta2-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, initial therapy: Patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., LABA, LAMA, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) For 18 years of age or older, patient has experienced an inadequate treatment response to Xhance (fluticasone).
Age Restrictions	Atopic Dermatitis: 6 months of age or older, Asthma: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis: 12 years of age or older, Chronic Obstructive Pulmonary Disease and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 1 year of age or older

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	AD, initial: 4 months, PN, initial: 6 months, All others: Plan Year
<b>Other Criteria</b>	<p>For eosinophilic esophagitis (EoE), initial therapy: 1) Diagnosis has been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field, AND 2) Patient is exhibiting clinical manifestations of the disease (for example, dysphagia), AND 3) Patient weighs at least 15 kilograms, AND 4) Patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid. For EoE, continuation of therapy: Patient achieved or maintained a positive clinical response. For prurigo nodularis (PN), initial therapy: Patient has had an inadequate treatment response to a topical corticosteroid OR topical corticosteroids are not advisable for the patient. For PN, continuation of therapy: Patient achieved or maintained a positive clinical response. For chronic obstructive pulmonary disease (COPD), initial therapy: 1) Patient is either of the following: a) currently receiving standard inhaled triple therapy (i.e., inhaled glucocorticoid, LAMA, and LABA) or b) currently receiving a LAMA and LABA, and has a contraindication to inhaled glucocorticoid, AND 2) Patient has an absolute blood eosinophil count of at least 300 cells per microliter prior to initiating therapy. For COPD, continuation of therapy: Patient achieved or maintained a positive clinical response.</p>

# ELIGARD

---

## Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent androgen receptor positive salivary gland tumors
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# EMSAM

## Products Affected

- Emsam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Major Depressive Disorder (MDD): 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion OR 2) The patient is unable to swallow oral formulations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ENDARI

---

## Products Affected

- Endari
- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	5 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# EPCLUSA

## Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	N/A

# EPIDIOLEX

---

## Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# EPO

## Products Affected

- Procrit

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndromes (MDS), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
<b>Exclusion Criteria</b>	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
<b>Required Medical Information</b>	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	16 weeks
<b>Other Criteria</b>	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

# EPRONTIA

## Products Affected

- Eprontia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	Epilepsy: 2 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ERGOTAMINE

## Products Affected

- Ergotamine Tartrate/caffeine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ERIVEDGE

## Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adult medulloblastoma
Exclusion Criteria	N/A
Required Medical Information	For adult medulloblastoma: patient has received prior systemic therapy AND has tumor(s) with mutations in the sonic hedgehog pathway.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ERLEADA

---

## Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ERLOTINIB

## Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ESBRIET

## Products Affected

- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ETANERCEPT

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hidradenitis suppurativa, non-radiographic axial spondyloarthritis
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient meets any of the following: a) the patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e. at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year



<b>Other Criteria</b>	N/A
-----------------------	-----

# EVEROLIMUS

## Products Affected

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

- Torpenz

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangi leiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, oncocyctic, and follicular), endometrial carcinoma, uterine sarcoma, breast cancer (in combination with fulvestrant or tamoxifen), histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis), meningiomas.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: 1) The disease is residual, recurrent, unresectable, or metastatic/tumor rupture, AND 2) The disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A

<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

## EXKIVITY

---

### Products Affected

- Exkivity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FANAPT

## Products Affected

- Fanapt

- Fanapt Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of schizophrenia: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to brand Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FASENRA

## Products Affected

- Fasenra

- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, AND 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, OR 3) no active vasculitis.
Age Restrictions	Asthma: 6 years of age or older, EGPA: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FENTANYL PATCH

## Products Affected

- Fentanyl PT72

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FETZIMA

## Products Affected

- Fetzima

- Fetzima Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# FINTEPLA

---

## Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FIRMAGON

---

## Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FLUCYTOSINE

---

## Products Affected

- Flucytosine CAPS 250MG, 500MG

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

# FORTEO

## Products Affected

- Teriparatide INJ 620MCG/2.48ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For glucocorticoid-induced osteoporosis: patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Initial: 24 months, Continuation: Plan Year
<b>Other Criteria</b>	Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Patient has high FRAX fracture probability if the 10-year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

# FOTIVDA

## Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: 1) The disease is advanced, relapsed, refractory or Stage IV, AND 2) The patient has received two or more prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FRUZAQLA

---

## Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# FYCOMPA

## Products Affected

- Fycompa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam.
Age Restrictions	Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# GATTEX

## Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short bowel syndrome (SBS) initial therapy: 1) for an adult patient, the patient has been dependent on parenteral support for at least 12 months OR 2) for a pediatric patient, the patient is dependent on parenteral support. For SBS continuation: requirement for parenteral support has decreased from baseline while on therapy with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist.
Coverage Duration	Plan Year
Other Criteria	N/A

# GAVRETO

## Products Affected

- Gavreto

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer, RET mutation-positive medullary carcinoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
<b>Age Restrictions</b>	Non-small cell lung cancer: 18 years of age or older, Thyroid cancer: 12 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# GILENYA

---

## Products Affected

- Fingolimod Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# GILOTRIF

## Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease AND a) has experienced an intolerable adverse event or contraindication to erlotinib, gefitinib or osimertinib, OR 2) has metastatic squamous NSCLC that progressed after platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# GLATIRAMER

---

## Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# GOMEKLI

---

## Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# GROWTH HORMONE

## Products Affected

- Genotropin

- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist.
Coverage Duration	Plan Year

<b>Other Criteria</b>	<p>Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. For pediatric GHD, TS, SGA, and adult GHD, continuation of therapy: Patient is experiencing improvement.</p>
-----------------------	---



# HAEGARDA

## Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

# HARVONI

## Products Affected

- Harvoni

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	N/A

# HETLIOZ

## Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS, AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	Non-24: 18 years of age or older, SMS: 16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist
Coverage Duration	Initiation: 6 months, Renewal: Plan Year
Other Criteria	N/A

## HIGH RISK MEDICATION - 65

### Products Affected

- Dicyclomine Hcl SOLN
- Dicyclomine Hydrochloride CAPS
- Dicyclomine Hydrochloride INJ
- Dicyclomine Hydrochloride TABS
- Dihydroergotamine Mesylate INJ
- Dipyrindamole TABS
- Disopyramide Phosphate CAPS
- Guanfacine Hydrochloride
- Guanfacine Hydrochloride Er
- Ketorolac Tromethamine TABS
- Methscopolamine Bromide TABS
- Perphenazine/amitriptyline
- Thioridazine Hydrochloride
- Trimethobenzamide Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

## HRM - ANTICONVULSANTS - 65

### Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG
- Phenobarbital Sodium INJ 130MG/ML, 65MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Epilepsy
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

## HRM - HYPNOTICS - 65

### Products Affected

- Zolpidem Tartrate TABS
- Zaleplon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For insomnia: 1) The patient meets one of the following: a) the patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) OR b) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND the patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.

## HRM - SCOPOLAMINE - 65

---

### Products Affected

- Scopolamine PT72 1MG/3DAYS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Excessive salivation
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.).

## HRM-ANTIPARKINSON - 65

### Products Affected

- Benztropine Mesylate TABS
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine OR 3) The patient has tried the non-HRM alternative drug amantadine AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)



## HRM-CYPROHEPTADINE - 65

### Products Affected

- Cyproheptadine Hcl SYRP
- Cyproheptadine Hydrochloride TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Pruritus, spasticity due to spinal cord injury
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior Authorization applies to greater than cumulative 30 days of therapy per year.

## HRM-DOXEPIN - 65

### Products Affected

- Doxepin Hcl CAPS 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 100MG, 10MG, 150MG, 25MG, 50MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

## HRM-HYDROXYZINE - 65

### Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.).

## HRM-HYDROXYZINE INJ - 65

### Products Affected

- Hydroxyzine Hcl INJ 25MG/ML

- Hydroxyzine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam OR 3) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	<p>This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)</p>

## HRM-PROMETHAZINE - 65

### Products Affected

- Promethazine Hcl INJ
- Promethazine Hcl SUPP 12.5MG
- Promethazine Hydrochloride SUPP 25MG
- Promethazine Hydrochloride TABS
- Promethazine Hydrochloride Plain
- Promethegan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 30 days of therapy per year.

## HRMS - ANTIDEPRESSANTS

### Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 100MG, 10MG, 50MG
- Desipramine Hydrochloride
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neuropathic pain, chronic tension-type headache prophylaxis (amitriptyline only)
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

# HRMS - CARBINOXAMINE

## Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS 4MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

## HRMS - CLEMASTINE- 65

### Products Affected

- Clemastine Fumarate TABS 2.68MG
- Clemasz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)



# HRMS - TCAS

## Products Affected

- Protriptyline Hcl
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

## HRM-SKELETAL MUSCLE RELAXANTS - 65

### Products Affected

- Chlorzoxazone TABS 500MG
- Cyclobenzaprine Hydrochloride TABS 10MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 2) If the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.

# HUMIRA

## Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter INJ 80MG/0.8ML
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter INJ 0

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, scalp, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) the patient meets any of the following: a) the patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) the patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) patient has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) the patient has a contraindication that would prohibit a trial of corticosteroids.

## HYPNOTIC-BENZODIAZEPINES - 65

### Products Affected

- Triazolam
- Temazepam CAPS 15MG, 22.5MG, 7.5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short-term treatment of insomnia: 1) Prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. Prior authorization applies to greater than cumulative 90 days of therapy per year.

# IBRANCE

## Products Affected

- Ibrance

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For breast cancer: 1) the disease is advanced, recurrent, or metastatic, AND 2) the patient has hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease, AND 3) the requested drug will be used in combination with an aromatase inhibitor or fulvestrant, AND 4) the patient has experienced an intolerable adverse event to Kisqali (ribociclib) OR Verzenio (abemaciclib) or has a contraindication to Kisqali (ribociclib) AND Verzenio (abemaciclib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ICATIBANT

## Products Affected

- Icatibant Acetate

- Sajazir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

# ICLUSIG

## Products Affected

- Iclusig

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase, Gastrointestinal Stromal Tumors
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Patient has accelerated or blast phase CML and no other kinase inhibitor is indicated, OR 2) Patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib, dasatinib, or nilotinib, OR 3) Patient is positive for the T315I mutation. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For gastrointestinal stromal tumors (GIST): 1) Disease meets any of the following: A) residual, B) unresectable, C) recurrent, D) metastatic/tumor rupture, AND 2) Disease has progressed after use of at least two Food and Drug Administration (FDA) approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A



# IDACIO

## Products Affected

- Adalimumab-aacf (2 Pen)
- Adalimumab-aacf (2 Syringe)
- Adalimumab-aacf Starter Pack/cd/uc/hs (6 Pen)
- Adalimumab-aacf Starter Pack/psoriasis/uveitis (4 Pen)
- Idacio (2 Pen)
- Idacio (2 Syringe)
- Idacio Starter Package For Crohns Disease
- Idacio Starter Package For Plaque Psoriasis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, scalp, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) the patient meets any of the following: a) the patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) the patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) patient has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) the patient has a contraindication that would prohibit a trial of corticosteroids.

# IDHIFA

## Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Newly-diagnosed acute myeloid leukemia
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient has newly-diagnosed AML and is not a candidate for intensive induction therapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# IMATINIB

## Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, cutaneous melanoma, Kaposi sarcoma, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFRΑ fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFRΑ, or PDGFRB rearrangement in the chronic phase or blast phase.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# IMBRUVICA

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	N/A

<b>Required Medical Information</b>	For mantle cell lymphoma: 1) the requested drug will be used as subsequent therapy AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Calquence (acalabrutinib), OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma: The requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed or refractory disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. For chronic lymphocytic leukemia/small lymphocytic lymphoma: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Calquence (acalabrutinib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# IMKELDI

## Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent chordoma, cutaneous melanoma, Kaposi sarcoma
Exclusion Criteria	N/A
Required Medical Information	For all indications: The patient is unable to use imatinib tablets. For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# IMPAVIDO

## Products Affected

- Impavido

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy. Sjogren-Larsson-Syndrome.
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A



# INBRIJA

## Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For initial treatment of off episodes in Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa, AND 2) The patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease. For continuation treatment of off episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# INCRELEX

## Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

# INLYTA

## Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (papillary, oncocytic, or follicular), alveolar soft part sarcoma
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: the disease is advanced, relapsed, or Stage IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# INQOVI

---

## Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## INREBIC

---

### Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	N/A
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# INSULIN SUPPLIES

## Products Affected

- Alcohol Prep Pads PADS 70%
- Bd Insulin Syringe Safetyglide/1ml/29g X 1/2"
- B-d Insulin Syringe Ultrafine Ii/0.3ml/31g X 5/16"
- Bd Insulin Syringe Ultra-fine/0.5ml/30g X 12.7mm
- Bd Insulin Syringe Ultra-fine/1ml/31g X 8mm
- Bd Pen Needle/original/ultra-fine/29g X 12.7mm
- Bd Veo Insulin Syringe Ultra-fine/0.3ml/31g X 6mm
- Curity Gauze Pads 2"x2" 12 Ply

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested product is being used with insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## IR BEFORE ER

### Products Affected

- Hydrocodone Bitartrate Er T24A
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadone Hydrochloride CONC
- Morphine Sulfate Er TBCR 100MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# IRESSA

## Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient must have a sensitizing epidermal growth factor receptor (EGFR) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# ISOTRETINOIN

## Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Zenatane

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Refractory acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ITOVEBI

---

## Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ITRACONAZOLE

## Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Coccidioidomycosis, Coccidioidomycosis prophylaxis in HIV infection,, Cryptococcosis, Microsporidiosis, Talaromycosis (formerly Penicilliosis), Histoplasmosis prophylaxis in HIV infection, Invasive fungal infection prophylaxis in liver transplant, chronic granulomatous disease (CGD), and hematologic malignancy, Sporotrichosis, Pityriasis versicolor, Tinea versicolor, Tinea corporis, Tinea cruris, Tinea capitis, Tinea manuum, Tinea pedis, primary treatment for allergic bronchopulmonary aspergillosis, primary treatment for chronic cavitary or subacute invasive (necrotizing) pulmonary aspergillosis
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The requested drug will be used orally. For the treatment of onychomycosis due to dermatophytes (Tinea unguium), the diagnosis has been confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy). For primary treatment of allergic bronchopulmonary aspergillosis, the requested drug is initiated in combination with systemic corticosteroids.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Disseminated/CNS histo, histo/CM/CGD ppx, chronic cavitary/necrotizing PA: 12 mths. Others: 6 mths
<b>Other Criteria</b>	N/A

# IVERMECTIN TAB

## Products Affected

- Ivermectin TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
Exclusion Criteria	N/A
Required Medical Information	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

# IVIG

## Products Affected

- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Privigen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# IWILFIN

---

## Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# JAKAFI

## Products Affected

- Jakafi

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Lower-risk myelofibrosis, accelerated or blast phase myeloproliferative neoplasms, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement, T-cell prolymphocytic leukemia
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For polycythemia vera: 1) patient had an inadequate response or intolerance to hydroxyurea and Besremi (ropeginterferon alfa-2b-njft), OR 2) patient has high risk disease. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# JAYPIRCA

## Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): The patient meets both of the following: 1) The patient has received prior treatment with a Bruton Tyrosine Kinase (BTK) inhibitor, for example Calquence (acalabrutinib), AND 2) The patient has received prior treatment with a B-cell lymphoma 2 (BCL-2) inhibitor. For mantle cell lymphoma: the patient has received prior treatment for a BTK inhibitor, for example Calquence (acalabrutinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# KALYDECO

---

## Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# KESIMPTA

---

## Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# KETOCONAZOLE

## Products Affected

- Ketoconazole TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Cushing's syndrome
<b>Exclusion Criteria</b>	Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine.
<b>Required Medical Information</b>	The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A

# KISQALI

---

## Products Affected

- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant. Endometrial cancer, in combination with letrozole, for estrogen receptor positive tumors.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# KORLYM

---

## Products Affected

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

# KOSELUGO

## Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive circumscribed glioma, Langerhans cell histiocytosis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For neurofibromatosis type 1: 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# KRAZATI

---

## Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), Central nervous system (CNS) brain metastases from KRAS G12C-positive NSCLC, KRAS G12C-positive pancreatic adenocarcinoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# KRISTALOSE

## Products Affected

- Kristalose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For constipation: 1) The patient has experienced an inadequate treatment response to a one month trial of generic lactulose solution, OR 2) The patient has experienced an intolerance that would prohibit a one month trial of generic lactulose solution, OR 3) the patient has a contraindication to an inactive ingredient in generic lactulose solution which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# LAPATINIB

## Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# LAZCLUZE

---

## Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LENVIMA

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma, unresectable or metastatic cutaneous melanoma.
Exclusion Criteria	N/A
Required Medical Information	For differentiated thyroid cancer (follicular, papillary, or oncocytic): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma (HCC): disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma (RCC): the disease is advanced, relapsed, or stage IV. For endometrial carcinoma (EC), the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LEUPROLIDE

## Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
<b>Age Restrictions</b>	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# LIBERVANT

---

## Products Affected

- Libervant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 to 5 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LIDOCAINE PATCHES

## Products Affected

- Lidocaine PTCH 5%
- Lidocan
- Tridacaine
- Tridacaine II

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# LINEZOLID

---

## Products Affected

- Linezolid INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

# LIVTENCITY

---

## Products Affected

- Livtency

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist.
Coverage Duration	3 months
Other Criteria	N/A



# LONSURF

## Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Unresectable locally advanced, recurrent, or metastatic esophageal cancer. Unresectable locally advanced or recurrent gastric cancer and gastroesophageal junction cancers. Advanced or metastatic appendiceal adenocarcinoma.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): The disease is advanced or metastatic. For gastric, esophageal, or gastroesophageal junction adenocarcinoma, ALL of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LORBRENA

## Products Affected

- Lorbrena

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC), proto-oncogene tyrosine-protein kinase ROS1 (ROS1) rearrangement-positive recurrent, advanced, or metastatic NSCLC, symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), central nervous system (CNS) brain metastases from ALK rearrangement-positive NSCLC, relapsed or refractory ALK-positive Diffuse Large B-Cell Lymphoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For recurrent, advanced, or metastatic non-small cell lung cancer: 1) Disease is ALK-positive AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib) OR 3) Disease is positive for ROS1 rearrangement and the requested drug is being used following disease progression on crizotinib, entrectinib, or ceritinib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# LUMAKRAS

---

## Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LUPRON PED

## Products Affected

- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Lupron Depot-ped (6-month)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LUPRON-ENDOMETRIOSIS

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, androgen receptor positive recurrent salivary gland tumor
Exclusion Criteria	N/A
Required Medical Information	For retreatment of endometriosis, the requested drug is used in combination with norethindrone acetate. For uterine fibroids, patient must meet one of the following: 1) diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	N/A

# LYNPARZA

## Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma.
Exclusion Criteria	N/A
Required Medical Information	For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: 1) The patient has a BRCA mutation and the requested drug will be used in combination with abiraterone and an oral corticosteroid OR 2) The patient has progressed on prior treatment with an androgen receptor-directed therapy. For ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the patient has had at least one prior therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LYRICA CR

---

## Products Affected

- Pregabalin Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For neuropathic pain associated with diabetic peripheral neuropathy (DPN) and postherpetic neuralgia (PHN): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# LYTGOBI

## Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extrahepatic cholangiocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For cholangiocarcinoma: 1) patient has a diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma, 2) patient has received a previous treatment, AND 3) patient has a disease that has a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# MAVYRET

## Products Affected

- Mavyret

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).
<b>Required Medical Information</b>	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	N/A

# MEKINIST

## Products Affected

- Mekinist

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# MEKTOVI

## Products Affected

- Mektovi

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Adjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis, recurrent non-small cell lung cancer (NSCLC)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with encorafenib, AND 3) The disease is advanced, recurrent, or metastatic.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# MEMANTINE

## Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN 2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This prior authorization only applies to patients less than 30 years of age.

# METFORMIN ER

---

## Products Affected

- Metformin Hydrochloride Er TB24 500MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance that prohibited a 4-week trial of metformin immediate-release and generic Glucophage XR.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# METHYLTESTOSTERONE

## Products Affected

- Methyltestosterone CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to alternative testosterone products (e.g., topical testosterone, transdermal testosterone, injectable testosterone). For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# MODAFINIL

## Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Idiopathic hypersomnia
Exclusion Criteria	N/A
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography. For idiopathic hypersomnia, initial request, the diagnosis has been confirmed by ALL of the following: 1) Patient has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) Insufficient sleep syndrome is confirmed absent, AND 3) Cataplexy is absent, AND 4) Fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) Average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) Another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results. For idiopathic hypersomnia, continuation of therapy: The patient has experienced a decrease in daytime sleepiness from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# MOUNJARO

---

## Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# NAPROXEN SUSPENSION

---

## Products Affected

- Naproxen SUSP

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ibuprofen oral suspension, AND 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

# NAYZILAM

---

## Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NERLYNX

---

## Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NEXAVAR

## Products Affected

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive and any of the following is met :1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is being used for low-intensity treatment induction, post-induction therapy, or consolidation therapy, OR 3) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, oncocyctic, or medullary. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# NINLARO

## Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NITISINONE

---

## Products Affected

- Nitisinone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) OR 2) DNA testing (mutation analysis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NORTHERA

## Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For neurogenic orthostatic hypotension (nOH): For initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy, patient has experienced a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

# NOXAFIL SUSP

## Products Affected

- Posaconazole SUSP

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.
Age Restrictions	13 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Oropharyngeal candidiasis: 1 month. All other indications: 6 months
Other Criteria	N/A



# NUBEQA

## Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NUEDEXTA

---

## Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pseudobulbar affect (PBA) (continuation): The patient has experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 4 months, Continuation: Plan Year
Other Criteria	N/A

# NUPLAZID

## Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# NURTEC

## Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT <sub>1</sub> receptor agonist. Preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Preventive treatment of migraine, initial: 3 months, All other indications: Plan Year
Other Criteria	N/A

# OCTREOTIDE

## Products Affected

- Octreotide Acetate INJ 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML, 50MCG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of thymomas and thymic carcinomas
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ODOMZO

## Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# OFEV

## Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# OGSIVEO

## Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# OJEMDA

## Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For relapsed or refractory pediatric low-grade glioma (LGG): the patient's tumor is positive for either a) BRAF fusion or rearrangement OR b) BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# OJJAARA

## Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	N/A
Required Medical Information	For myelofibrosis, patient meets ALL of the following: 1) the patient has a diagnosis of intermediate or high-risk primary myelofibrosis or secondary myelofibrosis (i.e., post-polycythemia vera or post-essential thrombocythemia), AND 2) the patient has anemia defined as hemoglobin less than 10 grams per deciliter (g/dL) or having transfusion-dependent anemia, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Jakafi (ruxolitinib) OR has hemoglobin less than 8 g/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## OMEGA-3

---

### Products Affected

- Omega-3-acid Ethyl Esters CAPS  
375MG; 465MG; 1GM

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypertriglyceridemia: Prior to the start of treatment with a triglyceride lowering drug, the patient has/had a pretreatment triglyceride level greater than or equal to 500 milligram per deciliter (mg/dL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ONCASPAR

## Products Affected

- Oncaspar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extranodal natural killer/T-cell lymphoma, aggressive NK-cell leukemia (ANKL)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ONUREG

## Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Peripheral T-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# OPSUMIT

## Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ORACEA AET

---

## Products Affected

- Doxycycline CPDR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a formulary generic topical metronidazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## ORAL-INTRANASAL FENTANYL

### Products Affected

- Fentanyl Citrate Oral Transmucosal LPOP 1600MCG, 200MCG, 400MCG, 800MCG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of breakthrough pain in cancer patients: 1) The requested drug is indicated for the treatment of breakthrough cancer-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a cancer patient with underlying cancer pain AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the cancer-related diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the cancer-related diagnosis.] AND 3) The patient is currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying cancer pain AND 4) The requested drug is intended only for use in opioid tolerant patients. The patient can safely take the requested dose based on their current opioid use history. [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# ORGOVYX

---

## Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ORKAMBI

## Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ORSERDU

## Products Affected

- Orserdu

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast cancer: 1) the disease is estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2)-negative, and ESR1 mutated AND 2) the patient meets either of the following: a) the disease is advanced, recurrent, or metastatic AND the patient has disease progression following at least one line of endocrine therapy OR b) the disease had no response to preoperative systemic therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

## OXAZEPAM - 65

### Products Affected

- Oxazepam

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders, anxiety associated with depression, and the management of anxiety, tension, agitation and irritability in older patients: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, Alcohol Withdrawal-Plan Year
<b>Other Criteria</b>	This Prior Authorization only applies to patients 65 years of age or older.

# OZEMPIC

---

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# PANRETIN

---

## Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# PEGASYS

## Products Affected

- Pegasys

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HCV: 12-48wks. HBV: 48wks. Other: Plan Yr
<b>Other Criteria</b>	N/A

# PEMAZYRE

---

## Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# PHENYL BUTYRATE

---

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# PIQRAY

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# POMALYST

## Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma, patient has previously received at least two prior therapies, including an immunomodulatory agent AND a proteasome inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# POSACONAZOLE

---

## Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs greater than 40 kilograms.
Age Restrictions	Treatment of Invasive Aspergillosis: 13 years of age or older, Prophylaxis of Invasive Aspergillus and Candida Infections: 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

# PREGABALIN

## Products Affected

- Pregabalin CAPS
- Pregabalin SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cancer-related neuropathic pain, cancer treatment-related neuropathic pain
Exclusion Criteria	N/A
Required Medical Information	For the management of postherpetic neuralgia, the management of neuropathic pain associated with diabetic peripheral neuropathy: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# PRETOMANID AET

## Products Affected

- Pretomanid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For tuberculosis (TB), patient meets ALL of the following: 1) the requested drug is being used for treatment of pulmonary extensively drug resistant (XDR), treatment intolerant or nonresponsive multidrug resistant (MDR) tuberculosis, AND 2) the requested drug is used in combination with bedaquiline and linezolid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# PREVYMIS

## Products Affected

- Prevymis PACK
- Prevymis TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 months
Other Criteria	N/A

# PULMOZYME

---

## Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.



# PYZCHIVA

## Products Affected

- Pyzchiva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# QINLOCK

## Products Affected

- Qinlock

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, recurrent, or progressive disease. Metastatic or unresectable cutaneous melanoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For residual, unresectable, tumor rupture, advanced, recurrent/metastatic, or progressive gastrointestinal stromal tumor (GIST): 1) Patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) Patient has experienced disease progression following treatment with avapritinib and dasatinib OR 3) Patient has received prior treatment with imatinib and is intolerant of second-line sunitinib. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# QUETIAPINE XR

## Products Affected

- Quetiapine Fumarate Er

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls].</p> <p>For treatment of schizophrenia: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of manic or mixed episodes associated with bipolar I disorder or maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of depressive episodes associated with bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: lurasidone, olanzapine, quetiapine immediate-release. For acute treatment of depressive episodes associated with bipolar II disorder: The patient experienced an inadequate treatment response or intolerance to generic quetiapine immediate-release. For adjunctive treatment of major depressive disorder (MDD): The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine immediate-release.</p>
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# QUININE SULFATE

---

## Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	N/A
Required Medical Information	For babesiosis: the requested drug is used in combination with clindamycin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

# QULIPTA

---

## Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

# RALDESY

## Products Affected

- Raldesy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient is unable to swallow trazodone tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# REGRANEX

---

## Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	N/A



# REPATHA

---

## Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# RETEVMO

## Products Affected

- Retevmo

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer (NSCLC), brain metastases from RET fusion-positive NSCLC, Langerhans Cell Histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, occult primary cancer with RET gene fusion, solid tumors with RET-gene fusion for recurrent disease
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC), patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement positive. For solid tumors, patient must meet all of the following: 1) The disease is recurrent, persistent, progressive, unresectable, locally advanced, or metastatic, 2) The patient has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options, AND 3) The tumor is RET fusion-positive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# REVLIMID

## Products Affected

- Lenalidomide

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, Rosai-Dorfman disease, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), human immunodeficiency virus (HIV)-related B-cell lymphomas, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castlemans disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# REVUFORJ

## Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# REZLIDHIA

---

## Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# REZUROCK

---

## Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# RINVOQ

## Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For moderately to severely active Crohn's disease (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For atopic dermatitis (new starts only): 1) Patient has refractory, moderate to severe disease, AND 2) Patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): Patient achieved or maintained positive clinical response. For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For non-radiographic axial spondyloarthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.</p>
Age Restrictions	Atopic dermatitis: 12 years of age or older

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Atopic dermatitis (initial): 4 months, All others: Plan Year
<b>Other Criteria</b>	For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).



# RINVOQ LQ

## Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For moderately to severely active Crohn's disease (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For atopic dermatitis (new starts only): 1) Patient has refractory, moderate to severe disease, AND 2) Patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): Patient achieved or maintained positive clinical response. For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For non-radiographic axial spondyloarthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.</p>
Age Restrictions	Atopic dermatitis: 12 years of age or older

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Atopic dermatitis (initial): 4 months, All others: Plan Year
<b>Other Criteria</b>	For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).

# ROMVIMZA

---

## Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ROZLYTREK

## Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors, ROS1-gene fusion-positive cutaneous melanoma
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors: the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer: the patient has recurrent, advanced, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# RUBRACA

## Products Affected

- Rubraca

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Uterine leiomyosarcoma, pancreatic adenocarcinoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, AND 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, AND 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy, OR 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy, AND 2) the patient has BRCA-altered disease. For pancreatic adenocarcinoma: 1) the patient has metastatic disease, AND 2) the patient has somatic or germline BRCA or PALB-2 mutations.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# RYBELSUS

---

## Products Affected

- Rybelsus TABS 14MG, 3MG, 7MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# RYDAPT

## Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-induction therapy for AML, re-induction in residual disease for AML
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SAPROPTERIN

## Products Affected

- Javygtor

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months, All others: Plan Year
Other Criteria	N/A



# SCSEMBLIX

## Products Affected

- Scemblix

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase or blast phase.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) in the chronic phase: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) Patient meets one of the following: A) Patient has newly diagnosed CML and has resistance or intolerance to imatinib, dasatinib, or nilotinib OR B) Patient has previously treated CML AND at least one of the prior treatments was imatinib, dasatinib, or nilotinib OR C) Patient is positive for the T315I mutation, AND 3) Patient is negative for the following mutations: A337T, P465S.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# SIGNIFOR

## Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

# SIKLOS

---

## Products Affected

- Siklos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SILDENAFIL

## Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SILDENAFIL INJ

## Products Affected

- Sildenafil INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	Patient was previously receiving oral Revatio or sildenafil but is now temporarily unable to take oral medications.

# SIRTURO

## Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Plan Year
Other Criteria	N/A

# SKYRIZI

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SOMATULINE DEPOT

## Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Tumor control of neuroendocrine tumors (NETs) (including tumors of the lung, thymus, well-differentiated grade 3 NETs not of gastroenteropancreatic origin with favorable biology, and pheochromocytoma/paraganglioma)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A



# SOMAVERT

## Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SOTYKTU

## Products Affected

- Sotyktu

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# SPRYCEL

## Products Affected

- Dasatinib

- Sprycel

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Gastrointestinal stromal tumor (GIST), metastatic and/or widespread chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, cutaneous melanoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: Diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene AND if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L OR 2) Ph-like B-ALL with ABL-class kinase fusion OR 3) Relapsed or refractory T-cell ALL with ABL-class translocation. For gastrointestinal stromal tumor (GIST): 1) Patient meets all of the following: A) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, B) Patient has received prior therapy with avapritinib AND C) Patient is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutations. For cutaneous melanoma: 1) Disease is metastatic or unresectable, 2) Disease is positive for c-KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# STELARA

## Products Affected

- Stelara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# STIVARGA

## Products Affected

- Stivarga

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, soft tissue sarcomas of the extremities, body wall, head and neck, appendiceal adenocarcinoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For colorectal cancer: 1) The disease is advanced or metastatic, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Lonsurf (trifluridine/tipiracil).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# SUTENT

## Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Thyroid carcinoma (follicular, medullary, papillary, and oncocytic), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase, pheochromocytoma, paraganglioma, well differentiated grade 3 neuroendocrine tumors
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For renal cell carcinoma (RCC): 1) The disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# SYMLIN

---

## Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# SYMPAZAN

## Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TABRECTA

## Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) brain metastases from MET exon-14 mutated NSCLC
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## TADALAFIL (BPH)

---

### Products Affected

- Tadalafil TABS 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Erectile Dysfunction.
Required Medical Information	For benign prostatic hyperplasia (BPH): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to both of the following: 1) alpha blocker, 2) 5-alpha reductase inhibitor (5-ARI).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	26 weeks
Other Criteria	N/A

## TADALAFIL (PAH)

### Products Affected

- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TAFINLAR

## Products Affected

- Tafinlar

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Langerhans cell histiocytosis, Erdheim-Chester disease.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The tumor is BRAF V600E-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) the requested drug will be used in combination with trametinib. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# TAGRISO

## Products Affected

- Tagrisso

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has unresectable, metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease, OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# TALZENNA

---

## Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TARGRETIN TOPICAL

## Products Affected

- Bexarotene GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS), chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# TASIGNA

## Products Affected

- Tasigna

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor, cutaneous melanoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. For gastrointestinal stromal tumor (GIST): 1) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, AND 2) Disease has progressed on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g. imatinib, sunitinib, regorafenib, ripretinib). For cutaneous melanoma: 1) Disease is metastatic or unresectable, AND 2) Disease is positive for c-KIT activating mutations, AND 3) Requested drug will be used as subsequent therapy, AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year

<b>Other Criteria</b>	N/A
-----------------------	-----

# TAVNEOS

## Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TAZAROTENE

## Products Affected

- Tazarotene CREA
- Tazarotene GEL
- Tazorac CREA 0.05%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TAZVERIK

---

## Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TECVAYLI

## Products Affected

- Tecvayli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TEMAZEPAM 30MG - 65

## Products Affected

- Temazepam CAPS 30MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

# TEPMETKO

## Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) cancer including brain metastases and leptomeningeal metastases from MET exon-14 mutated NSCLC
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# TESTOSTERONE ENANTHATE INJ

## Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TETRABENAZINE

## Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	N/A
Required Medical Information	For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease: The patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# THALOMID

## Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myelofibrosis-associated anemia, acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis, Kaposi sarcoma, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TIBSOVO

## Products Affected

- Tibsovo

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Conventional (grades 1-3) or dedifferentiated chondrosarcoma, central nervous system (CNS) cancers (astrocytoma, oligodendroglioma)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML. For locally advanced, unresectable, resected gross residual, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment. For CNS cancers: 1) disease is recurrent or progressive, AND 2) patient has oligodendroglioma or astrocytoma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# TOBI INHALER

## Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TOBRAMYCIN

## Products Affected

- Tobramycin NEBU 300MG/5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# TOPICAL DOXEPIN

---

## Products Affected

- Doxepin Hydrochloride CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

# TOPICAL LIDOCAINE

---

## Products Affected

- Lidocaine OINT 5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.



# TOPICAL TRETINOIN

---

## Products Affected

- Tretinoin CREA
- Tretinoin GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TOREMIFENE

## Products Affected

- Toremifene Citrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TREMFYA

## Products Affected

- Tremfya
- Tremfya Induction Pack For Crohns Disease

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TRIENTINE

---

## Products Affected

- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TRIKAFTA

---

## Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TRINTELLIX

---

## Products Affected

- Trintellix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ONE of the following generic products: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TRULICITY

---

## Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For glycemic control in type 2 diabetes mellitus:10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TRUQAP

---

## Products Affected

- Truqap

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# TRUXIMA

## Products Affected

- Truxima

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, pemphigus vulgaris, pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and pediatric mature B-cell acute leukemia
Exclusion Criteria	N/A

<b>Required Medical Information</b>	<p>For moderately to severely active rheumatoid arthritis (new starts only):</p> <p>1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD.</p> <p>Hematologic malignancies must be CD20-positive. For multiple sclerosis:</p> <p>1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
<b>Other Criteria</b>	N/A

# TUKYSA

## Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the patient has RAS wild-type disease, AND 4) the requested drug will be used in combination with trastuzumab, AND 5) the patient has not previously been treated with a HER2 inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TURALIO

## Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease
Exclusion Criteria	N/A
Required Medical Information	For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation AND patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# TYENNE

## Products Affected

- Tyenne

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Castleman's disease, systemic sclerosis-associated interstitial lung disease
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance or contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# UBRELVY

## Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VALCHLOR

## Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VALTOCO

---

## Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



## VANFLYTA

---

### Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory acute myeloid leukemia
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VELSIPITY

---

## Products Affected

- Velsipity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VENCLEXTA

## Products Affected

- Venclexta

- Venclexta Starting Pack

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), accelerated or blast phase myeloproliferative neoplasms, B-cell acute lymphoblastic leukemia/T-cell acute lymphoblastic leukemia (B-ALL/T-ALL), hairy cell leukemia
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 2) patient has poor/adverse risk disease and is a candidate for intensive induction therapy, OR 3) patient has relapsed or refractory AML. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with dexamethasone, AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# VEOZAH

---

## Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VERQUVO

## Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For symptomatic chronic heart failure: the patient has a left ventricular ejection fraction (LVEF) less than 45 percent. For initial therapy, the patient meets ANY of the following: 1) hospitalization for heart failure within the past 6 months OR 2) use of outpatient intravenous diuretics for heart failure within the past 3 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VERSACLOZ

## Products Affected

- Versacloz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VERZENIO

## Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	<p>Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.</p> <p>Endometrial cancer, in combination with letrozole for estrogen receptor positive tumor.</p>
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VICTOZA

## Products Affected

- Liraglutide INJ 6MG/ML
- Victoza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For glycemic control in type 2 diabetes mellitus: 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# VIGABATRIN

## Products Affected

- Vigabatrin
- Vigadrone
- Vigpoder

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures).
Age Restrictions	Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VIGAFYDE

---

## Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Infantile Spasms: 1 month to 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VITRAKVI

## Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VIZIMPRO

## Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC)
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, and 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VONJO

---

## Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Accelerated or blast phase myeloproliferative neoplasms
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VORANIGO

---

## Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VORICONAZOLE

---

## Products Affected

- Voriconazole INJ
- Voriconazole SUSR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient will use the requested drug orally or intravenously.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

# VOSEVI

## Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A



# VOTRIENT

## Products Affected

- Pazopanib Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (follicular, papillary, oncocytic, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: 1) the disease is advanced, relapsed, or stage IV, OR 2) the requested drug will be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture AND 2) the patient meets one of the following: a) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib), b) the disease is succinate dehydrogenase (SDH)-deficient GIST. For soft tissue sarcoma (STS): the patient does not have an adipocytic soft tissue sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# VOWST

## Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

# WELIREG

## Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# XALKORI

## Products Affected

- Xalkori

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis, metastatic or unresectable ROS1 gene fusion positive cutaneous melanoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, OR 4) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For inflammatory myofibroblastic tumor (IMT), the disease is ALK-positive. For anaplastic large cell lymphoma (ALCL): 1) the disease is relapsed or refractory, AND 2) the disease is ALK-positive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# XDEMVI

## Products Affected

- Xdemvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# XELJANZ

## Products Affected

- Xeljanz

- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]) AND 2) the requested drug is used in combination with a nonbiologic DMARD. For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For active polyarticular course juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

<b>Other Criteria</b>	N/A
-----------------------	-----

# XERMELO

## Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# XGEVA

## Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# XHANCE

## Products Affected

- Xhance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# XIFAXAN

## Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Small intestinal bacterial overgrowth syndrome (SIBO)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug, OR 2) The patient has previously received treatment with the requested drug, AND a) the patient is experiencing a recurrence of symptoms, AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug. For small intestinal bacterial overgrowth (SIBO): 1) the patient is experiencing a recurrence after completing a successful course of treatment with the requested drug OR 2) diagnosis has been confirmed by one of the following: a) quantitative culture of upper gut aspirate, b) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Reduction in risk of overt HE recurrence: 6 months, IBS-D and SIBO: 14 days
<b>Other Criteria</b>	N/A

# XOLAIR

## Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe persistent asthma, initial therapy (tx): 1) Patient (pt) has a positive skin test (or blood test) to at least one perennial aeroallergen, 2) Pt has baseline immunoglobulin E (IgE) level greater than or equal to 30 international units per milliliter (IU/mL), AND 3) Pt has inadequate asthma control despite current tx with both of the following medications: a) Medium-to-high-dose inhaled corticosteroid, AND b) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless pt has an intolerance or contraindication to such therapies. For moderate to severe persistent asthma, continuation of tx (COT): Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms (sx) and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic spontaneous urticaria (CSU), initial tx: 1) Pt has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1 (IL-1)-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Pt has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Pt remains symptomatic despite H1 antihistamine treatment. For CSU, COT: Pt has experienced a benefit (e.g., improved sx) since initiation of tx. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Pt has experienced inadequate treatment response to Xhance (fluticasone). For IgE-mediated food allergy, initial tx: Pt has baseline IgE level greater than or equal to 30 IU/mL. For IgE-mediated food allergy, COT: Pt has experienced a benefit as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal sx) to food allergen.
Age Restrictions	CSU: 12 years of age or older. Asthma: 6 years of age or older. CRSwNP: 18 years of age or older. IgE-mediated food allergy: 1 year of age or older

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CSU initial: 6 months, All others: Plan Year
<b>Other Criteria</b>	N/A

# XOSPATA

## Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement
Exclusion Criteria	N/A
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# XPOVIO

## Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, Human Immunodeficiency Virus (HIV)-related B-cell lymphoma, high-grade B-cell lymphoma, post-transplant lymphoproliferative disorders
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy. For B-cell lymphomas: Patient must have been treated with at least two lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# XTANDI

## Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



# XYREM

## Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient meets one of the following criteria: a) if the patient is 17 years of age or younger, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate), OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate), b) If the patient is 18 years of age or older, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
<b>Age Restrictions</b>	7 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a sleep disorder specialist or neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# YESINTEK

## Products Affected

- Yesintek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ZARXIO

## Products Affected

- Zarxio

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A

## ZEJULA

---

### Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Uterine leiomyosarcoma
Exclusion Criteria	N/A
Required Medical Information	For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ZELBORAF

## Products Affected

- Zelboraf

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Non-small cell lung cancer, hairy cell leukemia, central nervous system cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For central nervous system (CNS) cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ZIRABEV

## Products Affected

- Zirabev

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Ampullary adenocarcinoma, appendiceal adenocarcinoma, breast cancer, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

# ZOLINZA

---

## Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ZONISADE

## Products Affected

- Zonisade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A



## ZTALMY

---

### Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## ZURZUVAE

### Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

# ZYDELIG

## Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Small lymphocytic lymphoma (SLL)
Exclusion Criteria	N/A
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL): the requested drug is used as second-line or subsequent therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

# ZYKADIA

## Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
<b>Indications</b>	All FDA-approved Indications, Some Medically accepted Indications.
<b>Off-Label Uses</b>	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC, relapsed or refractory ALK-positive anaplastic large cell lymphoma (ALCL)
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib) OR 3) ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC. For anaplastic large cell lymphoma (ALCL): the patient has relapsed or refractory ALK-positive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	N/A

# ZYPREXA RELPREVV

---

## Products Affected

- Zyprexa Relprevv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

## PART B VERSUS PART D

---

### Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Astagraf XL
- Azathioprine INJ
- Azathioprine TABS 50MG
- Budesonide SUSP
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix 8/14
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Dextrose 50%
- Dextrose 70%
- Emend SUSR
- Engerix-b
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fiasp Pumpcart
- Gamastan
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Humulin R U-500 (concentrated)
- Hydromorphone Hydrochloride INJ 0.25MG/0.5ML
- Imovax Rabies (h.d.c.v.)
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Isolyte-s INJ 27MEQ/L; 98MEQ/L; 23MEQ/L; 3MEQ/L; 5MEQ/L; 140MEQ/L
- Isolyte-s Ph 7.4
- Jynneos
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Methylprednisolone TABS
- Methylprednisolone Acetate INJ 40MG/ML, 80MG/ML
- Methylprednisolone Sodium Succinate INJ 1000MG, 125MG
- Methylprednisolone Sodiumsuccinate INJ 40MG
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Morphine Sulfate/sodium Chloride INJ 1MG/ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nulojix
- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Pentamidine Isethionate INHALATION SOLR

- Plenamine INJ 147.4MEQ/L;  
2.17GM/100ML; 1.47GM/100ML;  
434MG/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
749MG/100ML; 1.04GM/100ML;  
1.18GM/100ML; 749MG/100ML;  
1.04GM/100ML; 894MG/100ML;  
592MG/100ML; 749MG/100ML;  
250MG/100ML; 39MG/100ML;  
960MG/100ML
- Prednisolone SOLN
- Prednisolone Sodium Phosphate ORAL  
SOLN 10MG/5ML, 15MG/5ML,  
20MG/5ML, 25MG/5ML, 5MG/5ML
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG,  
2.5MG, 20MG, 50MG, 5MG
- Prednisone Intensol
- Premasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 356MG/100ML;  
390MG/100ML; 34MG/100ML;  
152MG/100ML
- Prograf PACK
- Prosol
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tpn Electrolytes INJ 29.5MEQ/20ML;  
4.5MEQ/20ML; 35MEQ/20ML;  
5MEQ/20ML; 20MEQ/20ML;  
35MEQ/20ML
- Travasol INJ 52MEQ/L;  
1760MG/100ML; 880MG/100ML;  
34MEQ/L; 1760MG/100ML;  
372MG/100ML; 406MG/100ML;  
526MG/100ML; 492MG/100ML;  
492MG/100ML; 526MG/100ML;  
356MG/100ML; 500MG/100ML;  
356MG/100ML; 390MG/100ML;  
34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML;  
1.2GM/100ML; 0.32GM/100ML; 0; 0;  
0.5GM/100ML; 0.36GM/100ML;  
0.48GM/100ML; 0.82GM/100ML;  
1.4GM/100ML; 1.2GM/100ML;  
0.34GM/100ML; 0.48GM/100ML;  
0.68GM/100ML; 0.38GM/100ML;  
5MEQ/L; 0.025GM/100ML;  
0.42GM/100ML; 0.2GM/100ML;  
0.24GM/100ML; 0.78GM/100ML

## Details

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

# INDEX

## A

Abelcet .....	358
Abiraterone.....	1
Abiraterone Acetate.....	1
Abirtega.....	1
Accutane.....	153
Acetylcysteine .....	358
Acitretin.....	2
Actimmune .....	3
Acyclovir Sodium .....	358
Adalimumab-aacf (2 Pen) .....	137
Adalimumab-aacf (2 Syringe).....	137
Adalimumab-aacf Starter Pack/cd/uc/hs (6 Pen) .....	137
Adalimumab-aacf Starter Pack/psoriasis/uveitis (4 Pen) .....	137
Aimovig.....	4
Akeega.....	5
Albuterol Sulfate .....	358
Alcohol Prep Pads .....	150
Alecensa .....	6
Alosetron .....	7
Alosetron Hydrochloride.....	7
Alpha1-proteinase Inhibitor .....	8
Alunbrig .....	9
Alvaiz .....	10
Ambrisentan .....	12
Amitriptyline Hcl .....	126
Amitriptyline Hydrochloride.....	126
Amnesteem.....	153
Amphotericin B.....	358
Amphotericin B Liposome .....	358
Aprepitant.....	358
Arcalyst .....	13
Arikayce .....	14
Armodafinil .....	15
Asparlas.....	16

Astagraf XL .....	358
Aubagio.....	17
Augtyro .....	18
Austedo .....	19
Austedo Xr.....	19
Austedo Xr Patient Titration Kit.....	19
Auvelity.....	20
Ayvakit.....	21
Azathioprine.....	358

## B

Bafiertam.....	22
Balversa.....	23
Banzel .....	24
Bd Insulin Syringe Safetyglide/1ml/29g X 1/2..	150
B-d Insulin Syringe Ultrafine Ii/0.3ml/31g X 5/16 .....	150
Bd Insulin Syringe Ultra-fine/0.5ml/30g X 12.7mm .....	150
Bd Insulin Syringe Ultra-fine/1ml/31g X 8mm .	150
Bd Pen Needle/original/ultra-fine/29g X 12.7mm .....	150
Bd Veo Insulin Syringe Ultra-fine/0.3ml/31g X 6mm .....	150
Benlysta.....	25
Benzotropine Mesylate .....	120
Berinert .....	26
Besremi .....	27
Betaseron.....	28
Bexarotene .....	29, 280
Bosentan.....	30
Bosulif.....	31
Braftovi .....	32
Briviact.....	33, 34
Briviact Inj .....	34
Bronchitol .....	35
Brukina .....	36
Budesonide.....	358



Buprenorphine .....	37, 38
Buprenorphine Hcl .....	37
Buprenorphine Patch .....	38

## C

Cabometyx .....	39
Calcipotriene .....	40
Calcitrene .....	40
Calcitriol.....	40
Calquence .....	41
Caprelsa.....	42
Carac.....	43
Carbaglu .....	44
Carbinoxamine Maleate .....	127
Carglumic Acid .....	44
Cayston.....	45
Cerdelga .....	46
Chantix Aet .....	47
Chlordiazepoxide - 65 .....	48
Chlordiazepoxide Hcl.....	48
Chlordiazepoxide Hydrochloride .....	48
Chlorzoxazone.....	130
Claravis.....	153
Clemastine Fumarate.....	128
Clemasz .....	128
Clinimix 4.25%/dextrose 10% .....	358
Clinimix 4.25%/dextrose 5% .....	358
Clinimix 5%/dextrose 15% .....	358
Clinimix 5%/dextrose 20% .....	358
Clinimix 6/5 .....	358
Clinimix 8/10 .....	358
Clinimix 8/14 .....	358
Clinisol Sf 15% .....	358
Clinolipid.....	358
Clobazam.....	49
Clomipramine.....	50
Clomipramine Hydrochloride .....	50
Clorazepate.....	51
Clorazepate Dipotassium.....	51
Clozapine Odt.....	52
Cobenfy .....	53
Cobenfy Starter Pack.....	53
Colistimethate Sodium .....	54
Coly-mycin.....	54
Cometriq.....	55

Copiktra.....	56
Cosentyx .....	57
Cosentyx Sensoready Pen .....	57
Cosentyx Unoready.....	57
Cotellic .....	59
Cromolyn Sodium.....	358
Curity Gauze Pads 2.....	150
Cyclobenzaprine Hydrochloride .....	130
Cyclophosphamide.....	60
Cyclophosphamide Oral.....	60
Cyclosporine .....	358
Cyclosporine Modified .....	358
Cyproheptadine Hcl .....	121
Cyproheptadine Hydrochloride.....	121
Cystagon .....	61
Cystaran .....	62

## D

Dalfampridine .....	63
Dalfampridine Er .....	63
Danziten .....	64
Daraprim .....	65
Dasatinib .....	267
Daurismo.....	66
Deferasirox.....	67
Demser .....	68
Desipramine Hydrochloride.....	126
Dextrose 50%.....	358
Dextrose 70%.....	358
Dhe Nasal.....	69
Diacomit.....	70
Diazepam .....	71
Diazepam Aet.....	71
Diazepam Intensol .....	71
Dicyclomine Hcl .....	116
Dicyclomine Hydrochloride.....	116
Dihydroergotamine Mesylate.....	69, 116
Dipyridamole .....	116
Disopyramide Phosphate .....	116
Doxepin Hcl.....	122
Doxepin Hydrochloride .....	122, 295
Doxycycline .....	215
Drizalma.....	72
Drizalma Sprinkle .....	72
Dronabinol .....	73

Droxidopa.....	199
Dupixent.....	74

## **E**

Eligard.....	76
Emend.....	358
Emsam.....	77
Enbrel.....	88
Enbrel Mini.....	88
Enbrel Sureclick.....	88
Endari.....	78
Engerix-b.....	358
Epclusa.....	79
Epidiolex.....	80
Epo.....	81
Epoprostenol Sodium.....	358
Eprontia.....	82
Ergotamine.....	83
Ergotamine Tartrate/cafeine.....	83
Erivedge.....	84
Erleada.....	85
Erlotinib.....	86
Erlotinib Hydrochloride.....	86
Esbriet.....	87
Etanercept.....	88
Everolimus.....	90, 358
Exkivity.....	92

## **F**

Fanapt.....	93
Fanapt Titration Pack.....	93
Fasenra.....	94
Fasenra Pen.....	94
Fentanyl.....	95
Fentanyl Citrate Oral Transmucosal.....	216
Fentanyl Patch.....	95
Fetzima.....	96
Fetzima Titration Pack.....	96
Fiasp Pumpcart.....	358
Fingolimod Hydrochloride.....	107
Fintepla.....	97
Firmagon.....	98
Flucytosine.....	99
Fluorouracil.....	43
Forteo.....	100

Fotivda.....	102
Fruzaqla.....	103
Fycompa.....	104

## **G**

Gamastan.....	358
Gammaked.....	157
Gamunex-c.....	157
Ganciclovir.....	358
Gattex.....	105
Gavreto.....	106
Gefitinib.....	152
Gengraf.....	358
Genotropin.....	111
Genotropin Miniquick.....	111
Gilenya.....	107
Gilotrif.....	108
Glatiramer.....	109
Glatiramer Acetate.....	109
Glatopa.....	109
Gomekli.....	110
Granisetron Hydrochloride.....	358
Growth Hormone.....	111
Guanfacine Hydrochloride.....	116
Guanfacine Hydrochloride Er.....	116

## **H**

Haegarda.....	113
Harvoni.....	114
Heplisav-b.....	358
Hetlioz.....	115
High Risk Medication - 65.....	116
Hrm - Anticonvulsants - 65.....	117
Hrm - Hypnotics - 65.....	118
Hrm - Scopolamine - 65.....	119
Hrm-antiparkinson - 65.....	120
Hrm-cyproheptadine - 65.....	121
Hrm-doxepin - 65.....	122
Hrm-hydroxyzine - 65.....	123
Hrm-hydroxyzine Inj - 65.....	124
Hrm-promethazine - 65.....	125
Hrms - Antidepressants.....	126
Hrms - Carbinoxamine.....	127
Hrms - Clemastine- 65.....	128
Hrms - Tcas.....	129

Hrm-skeletal Muscle Relaxants - 65 .....	130
Humira.....	131
Humira Pen.....	131
Humira Pen-cd/uc/hs Starter .....	131
Humira Pen-pediatric Uc Starter Pack .....	131
Humira Pen-ps/uv Starter .....	131
Humulin R U-500 (concentrated).....	358
Hydrocodone Bitartrate Er .....	151
Hydromorphone Hydrochloride .....	358
Hydroxyzine Hcl .....	123, 124
Hydroxyzine Hydrochloride.....	123, 124
Hydroxyzine Pamoate .....	123
Hypnotic-benzodiazepines - 65 .....	133

## **I**

Ibrance.....	134
Icatibant.....	135
Icatibant Acetate.....	135
Iclusig.....	136
Idacio.....	137
Idacio (2 Pen) .....	137
Idacio (2 Syringe).....	137
Idacio Starter Package For Crohns Disease .....	137
Idacio Starter Package For Plaque Psoriasis .....	137
Idhifa .....	139
Imatinib .....	140
Imatinib Mesylate.....	140
Imbruvica .....	141
Imipramine Hcl .....	126
Imipramine Hydrochloride.....	126
Imkeldi .....	143
Imovax Rabies (h.d.c.v.) .....	358
Impavido.....	144
Inbrija .....	145
Increlex.....	146
Inlyta.....	147
Inqovi .....	148
Inrebic.....	149
Insulin Supplies .....	150
Ipratropium Bromide.....	358
Ipratropium Bromide/albuterol Sulfate .....	358
Ir Before Er.....	151
Iressa.....	152
Isolyte-s .....	358
Isolyte-s Ph 7.4.....	358

Isotretinoin .....	153
Itovebi .....	154
Itraconazole.....	155
Ivermectin .....	156
Ivermectin Tab .....	156
Ivig .....	157
Iwilfin.....	158

## **J**

Jakafi .....	159
Javygtor.....	256
Jaypirca .....	160
Jynneos.....	358

## **K**

Kalydeco .....	161
Kesimpta .....	162
Ketoconazole.....	163
Ketorolac Tromethamine .....	116
Kisqali .....	164
Kisqali Femara 200 Dose.....	164
Kisqali Femara 400 Dose.....	164
Kisqali Femara 600 Dose.....	164
Korlym .....	165
Koselugo .....	166
Krazati.....	167
Kristalose .....	168

## **L**

Lapatinib .....	169
Lapatinib Ditosylate.....	169
Lazcluze .....	170
Lenalidomide .....	243
Lenvima .....	171
Lenvima 10 Mg Daily Dose.....	171
Lenvima 12mg Daily Dose .....	171
Lenvima 14 Mg Daily Dose.....	171
Lenvima 18 Mg Daily Dose.....	171
Lenvima 20 Mg Daily Dose.....	171
Lenvima 24 Mg Daily Dose.....	171
Lenvima 4 Mg Daily Dose.....	171
Lenvima 8 Mg Daily Dose.....	171
Leuprolide .....	172
Leuprolide Acetate.....	172
Levalbuterol .....	358

Levalbuterol Hcl.....	358
Levalbuterol Hydrochloride .....	358
L-glutamine .....	78
Libervant .....	173
Lidocaine .....	174, 296
Lidocaine Patches.....	174
Lidocan.....	174
Linezolid.....	175
Liraglutide .....	320
Livtency .....	176
Lonsurf .....	177
Lorbrena .....	178
Lumakras .....	179
Lupron Depot (1-month) .....	181
Lupron Depot (3-month) .....	181
Lupron Depot-ped (1-month) .....	180
Lupron Depot-ped (3-month) .....	180
Lupron Depot-ped (6-month) .....	180
Lupron Ped .....	180
Lupron-endometriosis .....	181
Lynparza.....	182
Lyrica Cr .....	183
Lytgobi .....	184

## **M**

Mavyret .....	185
Mekinist.....	186
Mektovi .....	187
Memantine.....	188
Memantine Hcl Titration Pak.....	188
Memantine Hydrochloride .....	188
Memantine Hydrochloride Er .....	188
Metformin Er.....	189
Metformin Hydrochloride Er .....	189
Methadone Hcl .....	151
Methadone Hydrochloride .....	151
Methscopolamine Bromide .....	116
Methylprednisolone.....	358
Methylprednisolone Acetate .....	358
Methylprednisolone Sodium Succinate.....	358
Methylprednisolone Sodiumsuccinate .....	358
Methyltestosterone .....	190
Metyrosine.....	68
Mifepristone .....	165
Modafinil .....	191

Morphine Sulfate .....	358
Morphine Sulfate Er.....	151
Morphine Sulfate/sodium Chloride.....	358
Mounjaro.....	192
Mycophenolate Mofetil.....	358
Mycophenolic Acid Dr .....	358

## **N**

Naproxen.....	193
Naproxen Suspension.....	193
Nayzilam .....	194
Nerlynx .....	195
Nexavar .....	196
Ninlaro .....	197
Nitisinone.....	198
Northera .....	199
Noxafil Susp.....	200
Nubeqa .....	201
Nuedexta .....	202
Nulojix .....	358
Nuplazid.....	203
Nurtec.....	204
Nutrilipid.....	358

## **O**

Octagam .....	157
Octreotide.....	205
Octreotide Acetate .....	205
Odomzo.....	206
Ofev.....	207
Ogsiveo .....	208
Ojemda.....	209
Ojjaara.....	210
Omega-3.....	211
Omega-3-acid Ethyl Esters .....	211
Oncaspar .....	212
Ondansetron Hcl .....	358
Ondansetron Hydrochloride.....	358
Ondansetron Odt .....	358
Onureg.....	213
Opsumit.....	214
Oracea Aet .....	215
Oral-intranasal Fentanyl.....	216
Orgovyx .....	217
Orkambi .....	218

Orserdu .....	219
Oxazepam.....	220
Oxazepam - 65 .....	220
Ozempic .....	221

## **P**

Panretin.....	222
Part B Versus Part D .....	358
Pazopanib Hydrochloride .....	329
Pegasys .....	223
Pemazyre .....	224
Pentamidine Isethionate .....	358
Perphenazine/amitriptyline.....	116
Phenobarbital.....	117
Phenobarbital Sodium .....	117
Phenylbutyrate.....	225
Piqray .....	226
Piqray 200mg Daily Dose .....	226
Piqray 250mg Daily Dose .....	226
Piqray 300mg Daily Dose .....	226
Pirfenidone .....	87
Plenamine.....	359
Pomalyst.....	227
Posaconazole .....	200, 228
Posaconazole Dr.....	228
Prednisolone.....	359
Prednisolone Sodium Phosphate .....	359
Prednisone .....	359
Prednisone Intensol .....	359
Pregabalin.....	229
Pregabalin Er .....	183
Premasol.....	359
Pretomanid .....	230
Pretomanid Aet.....	230
Prevymis.....	231
Privigen .....	157
Procrit.....	81
Prograf.....	359
Prolastin-c.....	8
Promethazine Hcl .....	125
Promethazine Hydrochloride.....	125
Promethazine Hydrochloride Plain .....	125
Promethegan.....	125
Prosol.....	359
Protriptyline Hcl.....	129

Pulmozyme .....	232
Pyrimethamine .....	65
Pyzchiva.....	233

## **Q**

Qinlock.....	234
Quetiapine Fumarate Er .....	235
Quetiapine Xr.....	235
Quinine Sulfate .....	237
Qulipta.....	238

## **R**

Rabavert .....	359
Raldesy.....	239
Recombivax Hb .....	359
Regranex .....	240
Repatha .....	241
Repatha Pushtronex System.....	241
Repatha Sureclick .....	241
Retevmo .....	242
Revlimid.....	243
Revuforj .....	244
Rezlidhia .....	245
Rezurock .....	246
Rinvoq.....	247
Rinvoq Lq .....	249
Romvimza .....	251
Rozlytrek.....	252
Rubraca .....	253
Rufinamide.....	24
Rybelsus.....	254
Rydapt.....	255

## **S**

Sajazir .....	135
Sandimmune .....	359
Sapropterin.....	256
Sapropterin Dihydrochloride .....	256
Scemblix .....	257
Scopolamine.....	119
Signifor .....	258
Siklos.....	259
Sildenafil .....	260, 261
Sildenafil Citrate .....	260
Sildenafil Inj.....	261

Sirolimus .....	359
Sirturo .....	262
Skyrizi .....	263
Skyrizi Pen .....	263
Sodium Oxybate .....	345
Sodium Phenylbutyrate .....	225
Somatuline Depot .....	264
Somavert .....	265
Sorafenib Tosylate .....	196
Sotyktu .....	266
Sprycel .....	267
Stelara .....	269
Stivarga .....	270
Sunitinib Malate .....	271
Sutent .....	271
Symlin .....	272
Symlinpen 120 .....	272
Symlinpen 60 .....	272
Sympazan .....	273

## **T**

Tabrecta .....	274
Tacrolimus .....	359
Tadalafil .....	275, 276
Tadalafil (bph) .....	275
Tadalafil (pah) .....	276
Tafinlar .....	277
Tagrisso .....	278
Talzenna .....	279
Targretin Topical .....	280
Tasigna .....	281
Tasimelteon .....	115
Tavneos .....	283
Tazarotene .....	284
Tazorac .....	284
Tazverik .....	285
Tecvayli .....	286
Temazepam .....	133, 287
Temazepam 30mg - 65 .....	287
Tepmetko .....	288
Teriflunomide .....	17
Teriparatide .....	100
Testosterone Enanthate .....	289
Testosterone Enanthate Inj .....	289
Tetrabenazine .....	290

Thalomid .....	291
Thioridazine Hydrochloride .....	116
Tibsovo .....	292
Tobi Inhaler .....	293
Tobi Podhaler .....	293
Tobramycin .....	294
Topical Doxepin .....	295
Topical Lidocaine .....	296
Topical Tretinoin .....	297
Toremifene .....	298
Toremifene Citrate .....	298
Torpenz .....	90
Tpn Electrolytes .....	359
Travasol .....	359
Tremfya .....	299
Tremfya Induction Pack For Crohns Disease .....	299
Tretinoin .....	297
Triazolam .....	133
Tridacaine .....	174
Tridacaine II .....	174
Trientine .....	300
Trientine Hydrochloride .....	300
Trihexyphenidyl Hcl .....	120
Trihexyphenidyl Hydrochloride .....	120
Trikafta .....	301
Trimethobenzamide Hydrochloride .....	116
Trimipramine Maleate .....	129
Trintellix .....	302
Trophamine .....	359
Trulicity .....	303
Truqap .....	304
Truxima .....	305
Tukysa .....	307
Turalio .....	308
Tyenne .....	309

## **U**

Ubrelvy .....	310
---------------	-----

## **V**

Valchlor .....	311
Valtoco .....	312
Valtoco 10 Mg Dose .....	312
Valtoco 15 Mg Dose .....	312
Valtoco 20 Mg Dose .....	312

Valtoco 5 Mg Dose .....	312
Vanflyta .....	313
Varenicline Starting Month .....	47
Varenicline Tartrate .....	47
Velsipity .....	314
Venclexta .....	315
Venclexta Starting Pack .....	315
Veozah .....	316
Verquvo .....	317
Versacloz .....	318
Verzenio .....	319
Victoza .....	320
Vigabatrin .....	321
Vigadrone .....	321
Vigafyde .....	322
Vigpoder .....	321
Vitrakvi .....	323
Vizimpro .....	324
Vonjo .....	325
Voranigo .....	326
Voriconazole .....	327
Vosevi .....	328
Votrient .....	329
Vowst .....	330
<b>W</b>	
Welireg .....	331
<b>X</b>	
Xalkori .....	332
Xdemvy .....	333
Xeljanz .....	334

Xeljanz Xr .....	334
Xermelo .....	336
Xgeva .....	337
Xhance .....	338
Xifaxan .....	339
Xolair .....	340
Xospata .....	342
Xpovio .....	343
Xpovio 60 Mg Twice Weekly .....	343
Xpovio 80 Mg Twice Weekly .....	343
Xtandi .....	344
Xyrem .....	345
<b>Y</b>	
Yesintek .....	346
<b>Z</b>	
Zaleplon .....	118
Zarxio .....	347
Zejula .....	348
Zelboraf .....	349
Zenatane .....	153
Zirabev .....	350
Zolinza .....	351
Zolpidem Tartrate .....	118
Zonisade .....	352
Ztalmy .....	353
Zurzuvae .....	354
Zydelig .....	355
Zykadia .....	356
Zyprexa Relprevv .....	357