

ACTEMRA SQ

Products Affected

- Actemra ACTPen
- Actemra subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	Interstitial lung disease-18 years and older (initial and continuation)
Prescriber Restrictions	RA/GCA/PJIA/SJIA - Prescribed by or in consultation with a rheumatologist (initial therapy only). Lung disease-presc/consult-pulmonologist or rheum (initial and cont)
Coverage Duration	GCA-6mo initial, 1yr cont.PJIA-4mo initial, 1yr cont. other dx-3mo initial, 1yr cont. Lung dx-1 yr
Other Criteria	<p>RA initial - approve if the patient meets one of the following (A or B): patient has tried TWO of the following drugs in the past: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR (Note: if the patient does not meet this requirement, previous trial(s) with the following drugswill be counted towards meeting the try TWO requirement: Cimzia, infliximab, golimumab SC/IV), OR B) patient has heart failure or a previously treated lymphoproliferative disorder. PJIA initial, approve if the patient meets one of the following (A or B): patient has tried TWO of the following: Enbrel, Orencia, Xeljanz or Humira. (Note: if the patient does not meet this requirement, previous trial with the drug infliximab will be counted towards meeting the try TWO requirement), OR B) patient has heart failure or a previously treated lymphoproliferative disorder.Cont tx, RA/PJIA - approve if the pt had a response as determined by the prescriber.</p> <p>Interstitial lung disease associated with systemic sclerosis initial-approve if the patient has elevated acute phase reactants AND the diagnosis is confirmed by high-resolution computed tomography. Interstitial lung disease assoc with systemic sclerosis, Cont tx-approve if the patient had adequate efficacy.</p>
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

ACYCLOVIR (TOPICAL)

Products Affected

- acyclovir topical ointment

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another monoclonal antibody therapy
Required Medical Information	Diagnosis
Age Restrictions	18 years of age and older (initial therapy)
Prescriber Restrictions	Atopic Dermatitis-prescribed by or in consultation with an allergist, immunologist or dermatologist (initial therapy)
Coverage Duration	Initial-Atopic Dermatitis-4 months, Continuation-1 year
Other Criteria	Atopic Dermatitis, initial-patient has atopic dermatitis involvement estimated to be greater than or equal to 10 percent of the body surface area and patients meets a and b: a. Patient has tried at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid AND b. Inadequate efficacy was demonstrated with the previously tried topical corticosteroid therapy. Continuation- Approve if the patient has been receiving Adbry for at least 4 months and patient has responded to therapy. Note: A patient who has received less than 4 months of therapy or who is restarting therapy with Adbry should be considered under initial therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Ajovy, Vyepti or Emgality
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least one standard prophylactic pharmacologic therapy(e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AJOVY

Products Affected

- Ajoovy Autoinjector
- Ajoovy Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Aimovig, Vyepti or Emgality
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALPHA 1 PROTEINASE INHIBITORS

Products Affected

- Prolastin-C intravenous recon soln

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)-approve if the patient has a baseline (pretreatment) AAT serum concentration of less than 80 mg/dL or 11 micromol/L.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALUNBRIG

Products Affected

- Alunbrig oral tablet 180 mg, 30 mg, 90 mg
- Alunbrig oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	ALK status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANABOLIC STEROIDS

Products Affected

- oxandrolone

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia

ANTIBIOTICS (IV)

Products Affected

- amikacin injection solution 500 mg/2 mL
- ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg
- ampicillin-sulbactam injection
- azithromycin intravenous
- aztreonam
- Bicillin C-R
- Bicillin L-A
- ceftazidime
- ceftazidime
- cefuroxime sodium injection recon soln 750 mg
- cefuroxime sodium intravenous recon soln 1.5 gram
- ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 mL
- clindamycin in 5 % dextrose
- clindamycin phosphate injection
- clindamycin phosphate intravenous solution 600 mg/4 mL
- colistin (colistimethate Na)
- Doxy-100
- ertapenem
- Erythrocin intravenous recon soln 500 mg
- gentamicin in NaCl (iso-osm) intravenous piggyback 100 mg/100 mL, 60 mg/50 mL, 80 mg/100 mL, 80 mg/50 mL
- gentamicin injection solution 40 mg/mL
- imipenem-cilastatin
- levofloxacin in D5W intravenous piggyback 500 mg/100 mL, 750 mg/150 mL
- levofloxacin intravenous
- linezolid in dextrose 5%
- meropenem intravenous recon soln 1 gram, 500 mg
- metronidazole in NaCl (iso-os)
- moxifloxacin-sod.chloride(iso)
- nafcillin injection
- oxacillin in dextrose(iso-osm)
- oxacillin injection
- penicillin G pot in dextrose intravenous piggyback 2 million unit/50 mL, 3 million unit/50 mL
- penicillin G potassium injection recon soln 20 million unit
- penicillin G procaine intramuscular syringe 1.2 million unit/2 mL
- penicillin G sodium
- streptomycin
- Tazicef injection
- Teflaro
- tigecycline
- tobramycin sulfate injection solution
- vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANTIFUNGALS (IV)

Products Affected

- fluconazole in NaCl (iso-osm) intravenous piggyback 200 mg/100 mL, 400 mg/200 mL
- voriconazole

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent biologic therapy
Required Medical Information	N/A
Age Restrictions	Initial tx CAPS/Pericarditis-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
Coverage Duration	CAPS-3 mos initial, 1 yr cont. DIRA-6 mos initial, 1 yr cont. Pericard-3 mos initial, 1 yr cont
Other Criteria	CAPS renewal - approve if the patient has had a response as determined by the prescriber. DIRA initial-approve if the patient weighs at least 10 kg, genetic test confirms a mutation in the IL1RN gene and the patient has demonstrated a clinical benefit with anakinra subcutaneous injection. DIRA cont-approve if the patient has responded to therapy. Pericarditis initial-approve if the patient has recurrent pericarditis AND for the current episode, the patient is receiving standard treatment or standard treatment is contraindicated. Continuation-approve if the patient has had a clinical response.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous medication history
Age Restrictions	MAC-18 years and older
Prescriber Restrictions	MAC-Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections. Cystic fibrosis-prescribed by or in consultation with a pulmonologist or physician who specializes in the treatment of cystic fibrosis
Coverage Duration	1 year
Other Criteria	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex within the past 3 months after completion of a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Cystic fibrosis-patient has pseudomonas aeruginosa in culture of the airway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Cystic fibrosis pseudomonas aeruginosa infection

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	Relapsing form of MS, to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AVONEX

Products Affected

- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	GIST-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation. Myeloid/Lymphoid Neoplasms with eosinophilia-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation. Systemic mastocytosis-Approve if the patient has a platelet count greater than or equal to 50,000/mcL and patient has one of the following subtypes of advanced systemic mastocytosis-aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm or mast cell leukemia.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid/Lymphoid neoplasms with Eosinophilia

BAFIERTAM

Products Affected

- Bafiertam

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies, test results
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Urothelial Carcinoma, locally advanced or metastatic-approve if the patient has susceptible fibroblast growth factor receptor 3 or fibroblast growth factor receptor 2 genetic alterations AND the patient has progressed during or following prior platinum-containing chemotherapy or checkpoint inhibitor therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BENLYSTA

Products Affected

- Benlysta subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with Other Biologics
Required Medical Information	Diagnosis, medications that will be used in combination, autoantibody status
Age Restrictions	18 years and older (initial).
Prescriber Restrictions	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
Coverage Duration	SLE-Initial-4 months, cont-1 year. Lupus Nephritis-6 mo initial, 1 year cont
Other Criteria	Lupus Nephritis Initial-approve if the patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]. Cont-approve if the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA] AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other interferon products
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BETASERON/EXTAVIA

Products Affected

- Betaseron subcutaneous kit

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BEXAROTENE (ORAL)

Products Affected

- bexarotene oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BOSENTAN/AMBRISENTAN

Products Affected

- ambrisentan
- bosentan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
Age Restrictions	N/A
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH - prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 1 year.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)

BOSULIF

Products Affected

- Bosulif oral tablet 100 mg, 400 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Philadelphia chromosome positive Acute Lymphoblastic Leukemia

BRAFTOVI

Products Affected

- Braftovi oral capsule 75 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation. Colon or Rectal cancer- approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Mantle Cell Lymphoma - approve for 3 years if the patient has tried at least one prior therapy. Chronic lymphocytic leukemia/small lymphocytic lymphoma-approve if the patient has tried at least one prior therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic lymphocytic Leukemia (CLL). Small Lymphocytic Lymphoma (SLL)

C1 ESTERASE INHIBITORS

Products Affected

- Cinryze

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	1 year
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II], Prophylaxis, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient is currently taking Cinryze for prophylaxis - approve if the patient meets the following criteria (i and ii): i) patient has a diagnosis of HAE type I or II, and ii) according to the prescriber, the patient has had a favorable clinical response since initiating Cinryze as prophylactic therapy compared with baseline. HAE Due to C1-INH Deficiency [Type I or Type II], Treatment of Acute Attacks, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient who has treated previous acute HAE attacks with Cinryze: approve if the patient has a diagnosis of HAE Type I or Type II and according to the prescriber, the patient has had a favorable clinical response.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CABLIVI

Products Affected

- Cablivi injection kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent medications
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	Approve for 12 months
Other Criteria	aTTP-approve if the requested medication was initiated in the inpatient setting in combination with plasma exchange therapy AND patient is currently receiving at least one immunosuppressive therapy AND if the patient has previously received Cablivi, he/she has not had more than two recurrences of aTTP while on Cablivi.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, histology, RET gene rearrangement status
Age Restrictions	Thyroid carcinoma-12 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Renal Cell Carcinoma-Approve if the patient has relapsed or stage IV disease. Hepatocellular Carcinoma-approve if the patient has been previously treated with at least one other systemic therapy (e.g., Nexavar, Lenvima). GIST-approve if the patient has previously tried imatinib or avapritinib and has also tried one of the following: sunitinib, regorafenib or ripretinib. Bone cancer-approve if the patient has Ewing sarcoma or osteosarcoma and has tried at least one previous systemic regimen. Thyroid carcinoma-approve if the patient has differentiated thyroid carcinoma, patient is refractory to radioactive iodine therapy and the patient has tried a vascular endothelial growth factor receptor (VEGFR)-targeted therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements, Gastrointestinal stromal tumors (GIST), Bone cancer

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	MCL, CLL and SLL-approve. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma-approve if the patient has tried one prior therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma.

CAPRELSA

Products Affected

- Caprelsa oral tablet 100 mg, 300 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Non-Small Cell Lung Cancer with RET Gene Rearrangements

CARBAGLU

Products Affected

- Carbaglu
- carglumic acid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	NAGS-Pt meets criteria no genetic test - 3mo. Pt had genetic test - 12 mo, other-approve for 7 days
Other Criteria	N-Acetylglutamate synthase deficiency with hyperammonemia-Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency or if the patient has hyperammonemia. Propionic Acidemia or Methylmalonic Acidemia with Hyperammonemia, Acute Treatment-approve if the patient's plasma ammonia level is greater than or equal to 50 micromol/L and the requested medication will be used in conjunction with other ammonia-lowering therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) (generic carglumic acid)

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has <i>Pseudomonas aeruginosa</i> in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab test results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of Gaucher disease or related disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient is a cytochrome P450(CYP) 2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) as detected by an approved test
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHEMET

Products Affected

- Chemet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Blood lead level
Age Restrictions	Approve in patients between the age of 12 months and 18 years
Prescriber Restrictions	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
Coverage Duration	Approve for 2 months
Other Criteria	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHOLBAM

Products Affected

- Cholbam oral capsule 250 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination Therapy with Chenodal
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
Coverage Duration	3 mos initial, 12 mos cont
Other Criteria	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis or molecular genetic testing consistent with the diagnosis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS or molecular genetic testing consistent with the diagnosis AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improvement in steatorrhea) AND does not have complete biliary obstruction.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CIBINQO

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). Concurrent use with an Anti-Interleukin Monoclonal Antibody. Concurrent use with other Janus Kinase Inhibitors. Concurrent use with Xolair (omalizumab subcutaneous injection). Concurrent use with other potent immunosuppressants.
Required Medical Information	Diagnosis
Age Restrictions	AD-18 years of age and older (initial therapy)
Prescriber Restrictions	Atopic Dermatitis-prescribed by or in consultation with an allergist, immunologist or dermatologist (initial therapy)
Coverage Duration	Initial-Atopic Dermatitis-3 months, Continuation-1 year
Other Criteria	Atopic Dermatitis, initial-approve if the patient has had a 3-month trial of at least one traditional systemic therapy OR patient has tried at least one traditional systemic therapy but was unable to tolerate a 3-month trial. Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Continuation-Approve if the patient has been receiving Cibinqo for at least 90 days AND patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Cibinqo) in at least one of the following: estimated body surface area affected, erythema, induration/papulation/edema, excoriations, lichenification, and/or a decreased requirement for other topical or systemic therapies for atopic dermatitis AND compared with baseline (prior to receiving Cibinqo), patient experienced an improvement in at least one symptom, such as decreased itching. Note: A patient who has received less than 3 months of therapy or who is restarting therapy with Cibinqo should be considered under initial therapy.

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

CIMZIA

Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	18 years and older for CD and PP (initial therapy).
Prescriber Restrictions	All dx initial therapy only. RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist. PsA prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. nr-axSpA-prescribed by or in consultation with a rheumatologist
Coverage Duration	3 months initial, 1 year cont.
Other Criteria	AS initial tx, approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Xeljanz/XR, Taltz. PsA initial tx, approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Taltz, Stelara, Otezla, Orencia, Rinvoq, Skyrizi or Xeljanz/XR. RA initial tx, approve if the patient has tried two of the following drugs in the past: Enbrel, Humira, Orencia, Rinvoq or Xeljanz/XR. CD initial tx, approve if patient has previously tried Humira. Plaque Psoriasis (PP), initial tx-approve if the patient has tried TWO of the following drugs in the past: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Taltz. Cont tx, AS/PsA/RA/CD/PP - approve if the pt had a response as determined by the prescriber. Non-radiographic axial spondylitis (nr-axSpA), initial tx-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroilitis reported on MRI. nr-axSpA continuation tx-approve if the patient has had a response as determined by the prescriber.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

CLOBAZAM

Products Affected

- clobazam oral suspension
- clobazam oral tablet
- Sympazan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other medications tried
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Dravet Syndrome and treatment-refractory seizures/epilepsy

COMETRIQ

Products Affected

- Cometriq oral capsule 100 mg/day(80 mg x1-20 mg x1), 140 mg/day(80 mg x1-20 mg x3), 60 mg/day (20 mg x 3/day)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	<p>Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf. CNS Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i) Adjuvant treatment of pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for low-grade glioma or anaplastic glioma or glioblastoma, OR iii) melanoma with brain metastases AND medication will be taken in combination with Zelboraf (vemurafenib tablets).</p> <p>Histiocytic Neoplasm-approve if the patient meets one of the following (i, ii, or iii): i) patient has Langerhans cell histiocytosis and one of the following: multisystem disease or pulmonary disease or central nervous system lesions, OR ii) patient has Erdheim Chester disease, OR iii) patient has Rosai-Dorfman disease AND patient has BRAF V600 mutation-positive disease.</p>
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Cancer, Histiocytic Neoplasm

CRESEMBA (ORAL)

Products Affected

- Cresemba oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Candidiasis of the esophagus - HIV infection, sepsis

CRINONE GEL

Products Affected

- Crinone vaginal gel 8 %

PA Criteria	Criteria Details
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Support of an established pregnancy

CYSTEAMINE (OPHTHALMIC)

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year
Other Criteria	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CYSTEAMINE (ORAL)

Products Affected

- Cystagon

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Cystagon and Procysbi
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DALFAMPRIDINE

Products Affected

- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist (initial and continuation).
Coverage Duration	Initial-4months, Continuation-1 year
Other Criteria	Initial-approve if the requested medication is being used to improve or maintain mobility in a patient with MS. Continuation-approve if the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DALIRESP

Products Affected

- Daliresp

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DAURISMO

Products Affected

- Daurismo oral tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medications that will be used in combination, comorbidities
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML - approve if Daurismo will be used in combination with cytarabine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients continuing Daurismo as post-induction therapy

DEFERASIROX

Products Affected

- deferasirox

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve if the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DEFERIPRONE

Products Affected

- deferiprone
- Ferriprox

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias Initial therapy - approve. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-Initial therapy-approve if the patient is concomitantly receiving clobazam. Dravet Syndrome-Continuation-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DIMETHYL FUMARATE

Products Affected

- dimethyl fumarate oral capsule, delayed release (DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DOPTELET

Products Affected

- Doptelet (10 tab pack)
- Doptelet (15 tab pack)
- Doptelet (30 tab pack)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older (for chronic ITP-initial therapy only)
Prescriber Restrictions	Chronic ITP-prescribed by or after consultation with a hematologist (initial therapy)
Coverage Duration	Thrombo w/chronic liver disease-5 days, chronic ITP-initial-3 months, cont-1 year
Other Criteria	Thrombocytopenia with chronic liver disease-Approve if the patient has a current platelet count less than $50 \times 10^9/L$ AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy. Chronic ITP initial-approve if the patient has a platelet count less than 30,000 microliters or less than 50,000 microliters and is at an increased risk of bleeding and has tried one other therapy or if the patient has undergone splenectomy. Continuation-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- Dupixent Pen subcutaneous pen injector
200 mg/1.14 mL, 300 mg/2 mL
- Dupixent Syringe subcutaneous syringe
100 mg/0.67 mL, 200 mg/1.14 mL, 300 mg/2 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	AD-6 months and older, asthma-6 years of age and older, Esophagitis-12 and older, Chronic Rhinosinusitis-18 and older
Prescriber Restrictions	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist. Esophagitis-presc/consult-allergist or gastro
Coverage Duration	AD-Initial-4 mos, Cont-1 year, asthma/Rhinosinusitis/esophagitis-initial-6 months, cont 1 year
Other Criteria	AD-Init-meets a and b: a.has used at least 1 medium, med-high, high, and/or super-high-potency rx top corticosteroid OR has AD affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus oint AND b.Inadequate efficacy demonstrated w/previously tried topical RX, according to prescribing physician.Cont-Approve if pt has responded as determined by the prescribing physician.Asthma-Init-approve if pt meets following (i, ii, and iii):i.Pt meets 1 of the following(a or b):a)blood eosinophil level greater than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to tx with any IL tx or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received at least 3 consecutive mos combo therapy with BOTH of the following (a and b): a)ICS AND b)At least 1 additional asthma controller/maintenance med(NOTE:exception to the requirement for a trial of 1 additional asthma controller/maintenance med can be made if patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS for at least 3 consecutive mos. AND iii.asthma is uncontrolled or

PA Criteria	Criteria Details
	<p>was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by 1 of the following (a, b, c, d or e): a)experienced 2 or more asthma exacer requiring tx with systemic corticosteroids in the previous yr OR b)experienced 1 or more asthma exacer requiring hosp or an ED visit in the previous yr OR c)has a FEV1 less than 80% predicted OR d)has an FEV1/FVC less than 0.80 OR e)pt's asthma worsens upon tapering of oral corticosteroid tx. Cont-Approve if pt meets (i and ii): i.cont to receive tx with 1 ICS or 1 ICS-containing combo inhaler AND ii.has responded to Dupixent tx as determined by the prescribing physician. Chronic rhinosinusitis with Nasal Polyposis-Init-pt is currently receiving tx with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets 1 of the following (a or b): a)has received tx w/syst corticosteroid within previous 2 yrs or has a contraindication to systemic corticosteroid tx OR b)has had prior surgery for nasal polyps. Cont-approve if pt cont to receive tx with an intranasal corticosteroid AND pt has responded to Dupixent tx as determined by the prescriber. Eosinophilic esophagitis, initial-approve if pt weighs greater than or equal to 40 kg, has dx of eosinophilic esophagitis confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field, and does not have a secondary cause of eosinophilic esophagitis, and has received at least 8 wks of tx with a RX strength PPI. Cont-approve if pt has already received at least 6 mo of tx with Dupixent and pt has experienced reduced intraepithelial eosinophil count or decreased dysphagia/pain upon swallowing or reduced frequency/severity of food impaction.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMGALITY

Products Affected

- Emgality Pen
- EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Aimovig, Vyepti or Ajovy
Required Medical Information	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Cluster headache tx-6 months, migraine prevention-1 year
Other Criteria	Migraine headache prevention-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker), and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. Episodic cluster headache treatment-approve if the patient has between one headache every other day and eight headaches per day.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel Mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous solution
- Enbrel subcutaneous syringe
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	PP-4 years and older (initial therapy)
Prescriber Restrictions	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist. PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist. Uveitis, prescribed by or in consultation with an ophthalmologist.
Coverage Duration	FDA dx-6 mo init, 1 yr cont, Behcet's/uveitis init-6 mo, cont-12 mo.GVHD-3 mo
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other systemic therapy for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID), biologic or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first)

PA Criteria	Criteria Details
	<p>OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD-approve. Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives, Humira or an infliximab product. RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD, Uveitis Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.</p>
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Graft versus host disease (GVHD), Behcet's disease, Uveitis

EPCLUSA

Products Affected

- Epclusa oral pellets in packet 150-37.5 mg, 200-50 mg
- Epclusa oral tablet 200-50 mg, 400-100 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Patients 1 year and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-approve if the patient has tried at least two other antiepileptic drugs or if the patient has tried Diacomit, Fintepla or clobazam. Lennox Gastaut Syndrome-approve if the patient has tried at least two other antiepileptics drugs or if the patient has tried one of lamotrigine, topiramate, Banzel, felbamate or clobazam. Tuberous Sclerosis Complex-approve if the patient has tried at least two other antiepileptic drugs. Continuation of therapy-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EPOETIN ALFA

Products Affected

- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL
- Retacrit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, myelofibrosis- prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Chemo-6m,Transfus-1m, CKD-1yr, Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
Other Criteria	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-approve if according to the prescriber the patient has had a response. Anemia in patients with chronic renal failure on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundled payment benefit).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndrome (MDS), Myelofibrosis

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	BCC (La or Met) - must not have had disease progression while on Odomzo.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy. Central nervous system cancer (this includes brain and spinal cord tumors)-approve if the patient has tried at least one chemotherapy agent and according to the prescriber, the patient has a mutation of the sonic hedgehog pathway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central nervous System Cancer

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ERLOTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status, pancreatic cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced or Metastatic NSCLC, approve if the patient has sensitizing EGFR mutation positive non-small cell lung cancer as detected by an approved test. Note-Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. RCC, approve if the patient has recurrent or advanced non-clear cell histology RCC or if the patient had hereditary leiomyomatosis and renal cell carcinoma and erlotinib will be used in combination with bevacizumab. Bone cancer-approve if the patient has chordoma and has tried imatinib, dasatinib or sunitinib. Pancreatic cancer-approve if the medication is used in combination with gemcitabine. Vulvar cancer-approve if the patient has advanced, recurrent or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Renal Cell Carcinoma, vulvar cancer and Bone Cancer-Chordoma.

ESBRIET

Products Affected

- Esbriet oral capsule
- Esbriet oral tablet 267 mg, 801 mg
- pirfenidone oral tablet 267 mg, 801 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVEROLIMUS

Products Affected

- Afinitor Disperz
- Afinitor oral tablet 10 mg
- everolimus (antineoplastic) oral tablet
- everolimus (antineoplastic) oral tablet for suspension

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer-HER2 status, hormone receptor (HR) status.
Age Restrictions	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Breast Cancer-approve if the pt meets ALL the following criteria (A, B, C, D, E, and F): A)pt has recurrent or Stage IV, hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease AND B)pt has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C)pt has tried at least one prior endocrine therapy (e.g., anastrozole, letrozole, or tamoxifen) AND D)pt meets ONE of the following conditions (i or ii): i.pt is a postmenopausal female or a male OR ii.pt is premenopausal or perimenopausal AND is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin)), or has had surgical bilateral oophorectomy or ovarian irradiation AND E) The patient meets ONE of the following conditions (i or ii): i. If patient is a male AND if everolimus will be used in combination with exemestane, the patient is receiving a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin)) OR ii. everolimus will be used in combination with exemestane, Faslodex (fulvestrant intramuscular), or tamoxifen AND F) The patient has not had disease progression while on everolimus. Renal Cell Carcinoma (Clear Cell or Non-clear cell histology)-approve if the patient has relapsed or Stage IV disease and if using for clear cell disease, the patient has tried one prior

PA Criteria	Criteria Details
	<p>systemic therapy (e.g., Inlyta, Votrient, Sutent, Cabometyx, Nexavar). Tuberous sclerosis complex (TSC) Associated subependymal giant cell astrocytoma (SEGA)-approve if the patient requires therapeutic intervention but cannot be curatively resected. Thymomas and Thymic Carcinomas-approve if the patient has tried one prior chemotherapy (e.g., cisplatin plus doxorubicin, cisplatin plus etoposide, carboplatin plus paclitaxel).TSC associated renal angiomyolipoma-approve. WM/LPL - approve if patient has progressive or relapsed disease or if the patient has not responded to ONE primary therapy (e.g., Velcade with dexamethasone with or without Rituxan, Treanda with Rituxan, Rituxan with cyclophosphamide and dexamethasone, Treanda, Velcade with or without Rituxan, Velcade with dexamethasone, Kyprolis with Rituxan and dexamethasone, Imbruvica Rituxan). Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma-approve if the patient is refractory to radioactive iodine therapy. Endometrial Carcinoma-approve if everolimus will be used in combination with letrozole and the patient has recurrent, metastatic or high-risk disease. GIST-approve if the patient has tried TWO of the following drugs: Sutent, Stivarga, or imatinib AND there is confirmation that everolimus will be used in combination with one of these drugs (Sutent, Stivarga, or imatinib) in the treatment of GIST.Tuberous sclerosis complex (TSC)-associated partial-onset seizures-approve.</p>
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	<p>Advanced, unresectable or metastatic neuroendocrine tumors of the thymus (Carcinoid tumors).Soft tissue sarcoma-Perivascular Epithelioid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma, Endometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST) and Recurrent or progressive Meningioma, men with breast cancer</p>

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient meets (A, B and C): A) Patient has locally advanced or metastatic NSCLC AND B) Patient has epidermal growth factor receptor (EGFR) exon 20 insertion mutation, as determined by an approved test AND C) Patient has previously tried at least one platinum-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EYSUVIS

Products Affected

- Eysuvis

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody
Required Medical Information	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.
Other Criteria	<p>Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND meet both of the following criteria: 1) Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, or Theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following: a) patient experienced one or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS for at least 3 consecutive months. Continuation - The patient has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department</p>

PA Criteria	Criteria Details
	(ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-Initial therapy-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or patient has tried or is concomitantly receiving Epidiolex, clobazam or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy. Lennox-Gastaut Syndrome, initial-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Lennox-Gastaut Syndrome, continuation-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures (initial therapy)
Required Medical Information	Diagnosis, seizure history, lab and test results
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
Coverage Duration	Initial-3 months, Cont-1 year
Other Criteria	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Renal Cell Carcinoma (RCC)-approve if the patient has relapsed or Stage IV disease and has tried at least two other systemic regimens. Note: Examples of systemic regimens for renal cell carcinoma include axitinib tablets, axitinib + pembrolizumab injection, cabozantinib tablets, cabozantinib + nivolumab injection, sunitinib malate capsules, pazopanib tablets, sorafenib tablets, and lenvatinib capsules + everolimus.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	1 year and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
Coverage Duration	1 year
Other Criteria	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced at least a 20 percent decrease from baseline in the weekly volume of parenteral nutrition.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	NSCLC-18 years and older, MTC/thyroid cancer-12 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and rearranged during transfection (RET) fusion-positive disease detected by an Food and Drug Administration (FDA) approved test. Medullary thyroid cancer (MTC)-approve if the patient has advanced or metastatic rearranged during transfection (RET)-mutant disease and the disease requires treatment with systemic therapy. Thyroid cancer (other than MTC)-approve if the patient has advanced or metastatic rearranged during transfection (RET) fusion-positive disease, the disease is radioactive iodine-refractory AND the disease requires treatment with systemic therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILENYA

Products Affected

- Gilenya oral capsule 0.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of advanced or metastatic non small cell lung cancer (NSCLC)-approve if the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: examples of sensitizing EGFR mutation-positive NSCLC include the following mutations : exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. NSCLC metastatic squamous cell must have disease progression with first line treatment with platinum based chemotherapy. Head and neck cancer-approve if the patient has non-nasopharyngeal head and neck cancer and the patient has disease progression on or after platinum based chemotherapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Head and neck cancer

GLATIRAMER

Products Affected

- glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL
- Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Products Affected

- Bydureon BCise
- Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL
- Mounjaro
- Ozempic subcutaneous pen injector 0.25 mg or 0.5 mg(2 mg/1.5 mL), 1 mg/dose (4 mg/3 mL), 2 mg/dose (8 mg/3 mL)
- Rybelsus
- Trulicity
- Victoza 3-Pak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

Products Affected

- leuprolide subcutaneous kit
- Lupron Depot
- Lupron Depot (3 month)
- Lupron Depot (4 month)
- Lupron Depot (6 Month)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	uterine leiomyomata approve 3months/all other dx 12 mo
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors

GRALISE/HORIZANT/LYRICA CR

Products Affected

- Gralise oral tablet extended release 24 hr
300 mg, 600 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GROWTH HORMONES

Products Affected

- Omnitrope

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	<p>GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels).</p> <p>2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def], or prolactin).</p> <p>3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk</p> <p>4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate</p> <p>5.pt had a hypophysectomy. Cont-pt responding to therapy</p>
Age Restrictions	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
Coverage Duration	ISS - 6 mos initial, 12 months cont tx, SBS 1 month, others 12 mos

PA Criteria	Criteria Details
Other Criteria	<p>GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy. Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.</p>
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	CKD, SHOX, SBS

HARVONI

Products Affected

- Harvoni oral pellets in packet 33.75-150 mg, 45-200 mg
- Harvoni oral tablet 90-400 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	N/A
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

HETLIOZ

Products Affected

- Hetlitz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Non-24-patient is totally blind with no perception of light
Age Restrictions	Non-24-18 years or older (initial and continuation), SMS-16 years and older
Prescriber Restrictions	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders (initial and continuation)
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - patient is totally blind with no perception of light, dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont - Approve if patient is totally blind with no perception of light and pt has achieved adequate results with Hetlitz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep). Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Products Affected

- clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg
- Diazepam Intensol
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet
- Lorazepam Intensol
- lorazepam oral tablet 0.5 mg, 1 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = 12 months.
Other Criteria	All medically accepted indications other than insomnia, authorize use. Insomnia, may approve lorazepam if the patient has had a trial with two of the following: ramelteon, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BENZTROPINE

Products Affected

- benztropine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - CYCLOBENZAPRINE

Products Affected

- cyclobenzaprine oral tablet 10 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- hydroxyzine HCl oral tablet
- promethazine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - PHENOBARBITAL

Products Affected

- phenobarbital

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for use in sedation/insomnia.
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS- ESTROGENS

Products Affected

- Amabelz
- Dotti
- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet
- Fyavolv
- Jinteli
- Lyllana
- Menest oral tablet 0.3 mg, 0.625 mg, 1.25 mg
- Mimvey
- norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	For the treatment of Vulvar Vaginal Atrophy, approve if the patient has had a trial of one of the following for vulvar vaginal atrophy (brand or generic): Estradiol Vaginal Cream, Estring, or estradiol valerate. For prophylaxis of Postmenopausal Osteoporosis, approve if the patient has had a trial of one of the following (brand or generic): alendronate, ibandronate, risidronate or Raloxifene. The physician has assessed risk versus benefit in using this High Risk medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 40 mg/0.8 mL
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Pediatric UC
- Humira(CF) Pen Psor-Uv-Adol HS
- Humira(CF) Pen subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL
- Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC) 5 or older (initial therapy only), PP-18 or older (initial therapy only)
Prescriber Restrictions	Initial therapy only for all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	initial 6 mo, cont tx 1 year
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg,

PA Criteria	Criteria Details
	<p>MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ileocolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced (metastatic) hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used in combination with anastrozole, exemestane, or letrozole 2, pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonists, or has had surgical bilateral oophorectomy, or ovarian irradiation AND meets one of the following conditions: Ibrance will be used in combination with anastrozole, exemestane, or letrozole or Ibrance will be used in combination with fulvestrant 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Ibrance with be used in combination with anastrozole, exemestane or letrozole or Ibrance will be used in combination with fulvestrant 4. Pt is postmenopausal AND Ibrance will be used in combination with fulvestrant
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Liposarcoma

ICATIBANT

Products Affected

- icatibant
- Sajazir

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50 percent of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant - the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Approve if the patient meets one of the following: 1. Patient has CML or ALL that is Ph+, T315I-positive or, 2. patient has CML, chronic phase with resistance or intolerance to at least two prior TKIs or, 3. patient has accelerated phase or blast phase CML or Philadelphia chromosome positive ALL for whom no other TKIs are indicated.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	IDH2-mutation status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IMATINIB

Products Affected

- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	ASM, DFSP, HES, MDS/MPD-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	For ALL/CML, must have Ph-positive for approval of imatinib. Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)-patient has tried Turalio or according to the prescriber, the patient cannot take Turalio.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, advanced, aggressive or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.

IMBRUVICA

Products Affected

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral tablet 280 mg, 420 mg, 560 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	GVHD-1 year, all others-3 years
Other Criteria	Marginal Zone Lymphoma - Approve. GVHD-Approve if the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib, Jakafi). B-cell lymphoma-approve if the patient is using Imbruvica as second-line or subsequent therapy according to the prescribing physician. Central nervous system Lymphoma (primary)/Hairy Cell Leukemia-approve if relapsed or refractory.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Lymphoma (Primary), Hairy Cell Leukemia, B-Cell Lymphoma (e.g., follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma, AIDS related, post-transplant lymphoproliferative disorders).

IMPAVIDO

Products Affected

- Impavido

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	1 month
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INJECTABLE TESTOSTERONE PRODUCTS

Products Affected

- testosterone cypionate intramuscular oil 100 mg/mL, 200 mg/mL, 200 mg/mL (1 ML)
- testosterone enanthate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab results
Age Restrictions	Delayed puberty or induction of puberty in males-14 years and older
Prescriber Restrictions	N/A
Coverage Duration	Delayed puberty or induction of puberty in males-6 months, all others-12 months
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. Delayed puberty or induction of puberty in males - Approve testosterone enanthate. Breast cancer in females - Approve testosterone enanthate. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INLYTA

Products Affected

- Inlyta oral tablet 1 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate-2 or high-risk disease. Myeloid/Lymphoid Neoplasms with Eosinophilia-approve if the tumor has a JAK2 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid/Lymphoid Neoplasms with Eosinophilia

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has advanced or metastatic disease and the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IVIG

Products Affected

- Privigen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	ALL-less than 21 years of age, GVHD-12 and older, MF/PV/CMML-2/essential thrombo/myeloid/lymphoid neoplasm-18 and older
Prescriber Restrictions	N/A
Coverage Duration	GVHD-1 year, all others-3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea. ALL-approve if the mutation/pathway is Janus associated kinase (JAK)-related. GVHD, chronic-approve if the patient has tried one conventional systemic treatment for graft versus host disease. GVHD, acute-approve if the patient has tried one systemic corticosteroid. Polycythemia vera-approve if the patient has tried hydroxyurea. Atypical chronic myeloid leukemia-approve if the patient has a CSF3R mutation or a janus associated kinase mutation. Chronic monomyelocytic leukemia-2 (CMML-2)-approve if the patient is also receiving a hypomethylating agent. Essential thrombocythemia-approve if the patient has tried hydroxyurea, peginterferon alfa-2a or anagrelide. Myeloid/lymphoid neoplasms-approve if the patient has eosinophilia and the tumor has a janus associated kinase 2 (JAK2) rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute lymphoblastic leukemia, atypical chronic myeloid leukemia, chronic monomyelocytic leukemia-2 (CMML-2), essential thrombocythemia, myeloid/lymphoid neoplasms

JUXTAPID

Products Affected

- Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	12 months
Other Criteria	<p>Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) and had clinical manifestation of HoFH before the age of 10 years OR both parents of the patient had untreated LDL-C levels or total cholesterol levels consistent with HeFH OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL and had clinical manifestation of HoFH before the age of 10 years OR both parents of the patient had untreated LDL-C levels or total cholesterol levels consistent with HeFH, AND 2) Patient has tried at least one PCSK9 inhibitor for greater than or equal to 8 continuous weeks and the LDL-C level after this PCSK9 inhibitor therapy remains greater than or equal to 70 mg/dL OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level after these treatment regimens remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related</p>

PA Criteria	Criteria Details
	rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Trikafta or Symdeko
Required Medical Information	N/A
Age Restrictions	4 months of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	1 year
Other Criteria	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KISQALI

Products Affected

- Kisqali Femara Co-Pack oral tablet 200 mg/day(200 mg x 1)-2.5 mg, 400 mg/day(200 mg x 2)-2.5 mg, 600 mg/day(200 mg x 3)-2.5 mg
- Kisqali oral tablet 200 mg/day (200 mg x 1), 400 mg/day (200 mg x 2), 600 mg/day (200 mg x 3)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Kisqali with be used in combination with anastrozole, exemestane or letrozole. 4. Patient is postmenopausal (patient receiving ovarian suppression/ablation with a GnRH agonist or has had surgical bilateral oophorectomy or ovarian irradiation) or a man, and Kisqali (not Co-Pack) will be used in combination with fulvestrant. If the request is for Kisqali Femara, patients do not need to use in combination with anastrozole, exemestane or letrozole. Patients must have a trial of Ibrance or Verzenio prior to approval of Kisqali/Kisqali Femara Co-Pack unless the patient meets one of the following-a) Patient has been taking

PA Criteria	Criteria Details
	Kisqali or Kisqali Femara Co-Pack and is continuing therapy OR b) Patient is pre/perimenopausal and will be using Kisqali or Kisqali Femara Co-Pack in combination with an aromatase inhibitor as initial endocrine-based therapy OR c) Kisqali will be used in combination with fulvestrant in postmenopausal female or male patients as initial endocrine-based therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
Coverage Duration	Endogenous Cushing's Synd-1 yr. Patients awaiting surgery/response after radiotherapy-4 mo
Other Criteria	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Endogenous Cushing's Syndrome, awaiting surgery. Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy

KYNMOBI

Products Affected

- Kynmobi sublingual film 10 mg, 15 mg, 20 mg, 25 mg, 30 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's Disease-Approve if the patient is experiencing off episodes, such as muscle stiffness, slow movements or difficulty starting movements, is currently receiving carbidopa/levodopa and has previously tried one other treatment for off episodes and experienced intolerance or inadequate efficacy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LAPATINIB

Products Affected

- lapatinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	HER2-positive advanced or metastatic breast cancer, approve if the patient has received prior therapy with trastuzumab and lapatinib will be used in combination with capecitabine OR lapatinib will be used in combination with trastuzumab. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man receiving a GnRH agonist, a premenopausal or perimenopausal woman receiving ovarian suppression/ablation with a GnRH agonist, surgical bilateral oophorectomy or ovarian radiation or a postmenopausal woman and lapatinib will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or exemestane. In this criteria, man/woman is defined as an individual with the biological traits of a man/woman, regardless of the individual's gender identity or expression. Colon or rectal cancer-approve if the patient has unresectable advanced or metastatic disease that is human epidermal receptor 2 (HER2) amplified and with wild-type RAS and the medication is used as subsequent therapy in combination with trastuzumab (the requirement of use in combination with trastuzumab only applies to beneficiaries enrolled in an MA-PD plan) and the patient has not been previously treated with a HER2-inhibitor. Bone Cancer-chordoma-approve if the patient has epidermal growth-factor receptor (EGFR)-positive recurrent disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone cancer-chordoma, colon or rectal cancer

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	DTC - must be refractory to radioactive iodine treatment for approval. RCC, advanced disease - approve if the pt meets i or ii:i. Lenvima is is being used in combination with pembrolizumab OR ii. Lenvima is used in combination with everolimus and the patient meets a or b-a. Patient has clear cell histology and patient has tried one antiangiogenic therapy or b. patient has non-clear cell histology. MTC-approve if the patient has tried Caprelsa or Cometriq. Anaplastic thyroid cancer-approve if the disease does not have a curative option. Endometrial Carcinoma-Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND B) The medication is used in combination with Keytruda (pembrolizumab for intravenous injection) AND C)the disease has progressed on at least one prior systemic therapy AND D) The patient is not a candidate for curative surgery or radiation.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Medullary Thyroid Carcinoma (MTC) and anaplastic thyroid carcinoma.

LEUKINE

Products Affected

- Leukine injection recon soln

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Neuroblastoma-less than 18 years of age
Prescriber Restrictions	AML if prescribed by or in consultation with an oncologist or hematologist, PBPC/BMT - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation, Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome.Neuroblastoma-prescribed by or in consultation with an oncologist.
Coverage Duration	Radiation Syndrome/BMT - 1 mo, AML/Neuroblastoma-6 months, PBPC-14 days
Other Criteria	Neuroblastoma-approve if the patient is receiving Leukine in a regimen with dinutuximab.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neuroblastoma

LIDOCAINE PATCH

Products Affected

- lidocaine topical adhesive patch,medicated
5 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain, chronic back pain

LONG ACTING OPIOIDS

Products Affected

- Belbuca
- buprenorphine transdermal patch
- hydromorphone oral tablet extended release 24 hr
- methadone oral solution 10 mg/5 mL, 5 mg/5 mL
- methadone oral tablet 10 mg, 5 mg
- morphine oral tablet extended release
- OxyContin oral tablet, oral only, ext. rel. 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	Acute (ie, non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastric or Gastroesophageal Junction Adenocarcinoma-approve if the patient has been previously treated with at least two chemotherapy regimens for gastric or gastroesophageal junction adenocarcinoma.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LORBRENA

Products Affected

- Lorbrena oral tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, ALK status, ROS1 status, previous therapies
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC, as detected by an approved test. NSCLC-ROS1 Rearrangement-Positive-approve if the patient has tried at least one of crizotinib, entrectinib or ceritinib.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-small cell lung cancer (NSCLC)-ROS1 Rearrangement-Positive

LOTRONEX

Products Affected

- alosetron

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an FDA-approved test AND has been previously treated with at least one systemic regimen.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	<p>Ovarian Cancer-Treatment-initial-Approve if pt meets the following criteria (i and ii): i.pt has a germline BRCA-mutation as confirmed by an approved test AND per product labeling the patient has progressed on three or more prior lines of chemotherapy. Cont-approve if pt has a BRCA mutation (germline) as confirmed by an approved test. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if pt meets one of the following criteria (A or B): A)pt meets both of the following criteria for first-line maintenance therapy (i and ii): i.pt has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii.pt is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B)pt is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). Ovarian, fallopian tube, or primary peritoneal cancer-maintenance, combination therapy-approve if the medication is used in combination with bevacizumab, the patient has homologous recombination deficiency (HRD)-positive disease, as confirmed by an approved test and the patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Breast Cancer-Approve if the pt meets the following criteria (A, B and C)-A.pt has metastatic, germline BRCA mutation-positive breast cancer AND B.pt</p>

PA Criteria	Criteria Details
	<p>meets ONE of the following criteria (i or ii)- i. pt meets BOTH of the following criteria (a and b)-a)pt has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b)pt meets ONE of the following criteria (1 or 2)-1-pt has been treated with prior endocrine therapy OR-2 pt is considered inappropriate for endocrine therapy OR ii. Pt has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND C.pt has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. Pancreatic Cancer-maintenance therapy-approve if the patient has a germline BRCA mutation-positive metastatic disease and the disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. Prostate cancer-castration resistant-approve if the pt has metastatic disease, the medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog or the pateint has had a bilateral orchiectomy, the patient has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test, the pt does not have a PPP2R2A mutation and the patient has been previously treated with at least one androgen receptor directed therapy. Uterine Leiomyosarcoma-approve if the patient has BRCA2-altered disease and has tried one systemic regimen.</p>
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Uterine Leiomyosarcoma

MEGACE

Products Affected

- megestrol oral suspension 400 mg/10 mL (40 mg/mL), 625 mg/5 mL (125 mg/mL)
- megestrol oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKINIST

Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC requires BRAF V600E Mutation and use in combination with Tafenlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafenlar, unless intolerant AND the patient has BRAF V600-positive disease. Ovarian/fallopian tube/primary peritoneal cancer-approve if the patient has recurrent disease and the medication is used for low-grade serous carcinoma. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Tafenlar. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of one of the following conditions: pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for one of the following conditions: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Tafenlar (dabrafenib). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the

PA Criteria	Criteria Details
	following: multisystem disease or pulmonary disease or central nervous system lesions or patient has Erdheim Chester disease or Rosai-Dorfman disease AND patient has BRAF V600-mutation positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian/Fallopian Tube/Primary Peritoneal Cancer, Biliary Tract Cancer, Central Nervous System Cancer, Histiocytic Neoplasm

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEMANTINE

Products Affected

- memantine oral capsule, sprinkle, ER 24hr
- memantine oral solution
- memantine oral tablet
- Namzaric

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Indication for which memantine is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with mild to moderate vascular dementia.

MIGLUSTAT

Products Affected

- miglustat

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of Gaucher disease or related disorders
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MODAFINIL/ARMODAFINIL

Products Affected

- armodafinil
- modafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD)-approve if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome-approve. Excessive daytime sleepiness associated with Narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Approve if the patient has a current platelet count less than 50 x 10 ⁹ /L AND the patient is scheduled to undergo a procedure within 8 to 14 days after starting Mulpleta therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND the patient is responding to Natpara therapy, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other medications used at the same time
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Stage of cancer, HER2 status, previous or current medications tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Adjuvant tx-Approve for 1 year (total), advanced or metastatic disease-3yrs
Other Criteria	Breast cancer, adjuvant therapy - approve if the patient meets all of the following criteria: Patient has HER2-positive breast cancer AND patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy. Breast cancer, advanced, recurrent or metastatic disease-approve if the patient has HER-2 positive breast cancer, Nerlynx will be used in combination with capecitabine and the patient has tried at least two prior anti-HER2 based regimens.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve if disease is FLT3-ITD mutation positive as detected by an approved test. Renal cell carcinoma (RCC)-approve if the patient has relapsed or Stage IV clear cell histology and the patient has tried at least one prior systemic therapy (e.g., Inlyta, Votrient, Sutent Cabometyx). Ovarian, fallopian tube, primary peritoneal cancer-approve if the patient has platinum resistant disease and Nexavar is used in combination with topotecan.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Osteosarcoma, angiosarcoma, desmoids tumors (aggressive fibromatosis), gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma, ovarian, fallopian tube, primary peritoneal cancer

NEXLETOL

Products Affected

- Nexletol

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	<p>Heterozygous Familial Hypercholesterolemia (HeFH) -approve if pt meets one of the following: patient has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR patient has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR patient has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. Atherosclerotic Cardiovascular Disease (ASCVD) -approve if pt meets all of the following: Pt has one of the following conditions: prior MI, history of ACS, diagnosis</p>

PA Criteria	Criteria Details
	<p>of angina (stable or unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) AND ezetimibe concomitantly for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NEXLIZET

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	<p>Heterozygous Familial Hypercholesterolemia (HeFH) -approve if pt meets one of the following: has an untreated low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL (prior to treatment with antihyperlipidemic agents) OR has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 or low-density lipoprotein receptor adaptor protein 1 gene OR has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b): a) The prescriber used the Dutch Lipid Network criteria and the patient has a score greater than 5 OR b) The prescriber used the Simon Broome criteria and the patient met the threshold for definite or possible familial hypercholesterolemia AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation. Atherosclerotic Cardiovascular Disease (ASCVD) - approve if pt meets all of the following: Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina (stable or</p>

PA Criteria	Criteria Details
	unstable), history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND Pt tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) for greater than or equal to 8 continuous weeks and LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NILUTAMIDE

Products Affected

- nilutamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone OR pt had received at least ONE previous therapy for multiple myeloma (e.g., Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone) OR the agent will be used following autologous stem cell transplantation (ASCT). Systemic light chain amyloidosis-approve if the patient has tried at least one other regimen for this condition. Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma-approve if used in combination with a rituximab product and dexamethasone (applies only to beneficiaries enrolled in an MA-PD plan).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with systemic light chain amyloidosis, Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma

NITISINONE

Products Affected

- nitisinone

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant therapy with nitisinone products
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Hereditary Tyrosinemia, Type 1-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NIVESTYM

Products Affected

- Nivestym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4mo.MDS-3mo.PBPC,Drug induce A/N,AA,ALL,BMT-3mo. Radia-1mo.other-12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia

PA Criteria	Criteria Details
	[absolute neutrophil account less than 100 cells/mm ³], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).

NON-INJECTABLE TESTOSTERONE PRODUCTS

Products Affected

- Androderm 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal solution in metered pump w/app
- testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram),

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

NORTHERA

Products Affected

- droxidopa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	12 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Prostate cancer - non-metastatic, castration resistant-approve if the requested medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- Nucala subcutaneous auto-injector
- Nucala subcutaneous syringe 100 mg/mL
- Nucala subcutaneous recon soln

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
Required Medical Information	N/A
Age Restrictions	Asthma-6 years of age and older. EGPA/Polyps-18 years of age and older. HES-12 years and older.
Prescriber Restrictions	Asthma-Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA-prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist. HES-prescribed by or in consultation with an allergist, immunologist, hematologist, pulmonologist or rheumatologist. Polyps-prescribed by or in consult with allergist, immunologist or Otolaryngologist.
Coverage Duration	Initial-Asthma/EGPA/polyps-6 months, HES-8 months. 12 months continuation.
Other Criteria	Asthma initial-must have blood eosinophil level of greater than or equal to 150 cells per microliter within the prev 6 wks(prior to treatment with any anti-interleukin (IL)-5 therapy) AND Pt has received at least 3 consecutive mo of combo tx with an inhaled corticosteroid AND at least 1 additional asthma controller/maintenance med AND pt's asthma cont to be uncontrolled, or was uncontrolled prior to starting any anti-IL tx as defined by 1 of the following-pt exp 2 or more asthma exacerbations requiring tx with systemic corticosteroids in the prev yr, pt experienced 1 or more asthma exacerbation requiring hospital or an ED visit in the prev yr, pt has a FEV1 less than 80 percent predicted, Pt has an FEV1/FVC less than 0.80, or Pt's asthma worsens upon taper of oral corticosteroid tx.NOTE:An exception to the requirement for trial of 1 additional asthma controller/maintenance medication can be made if the pt has already received anti-IL-5 tx used concomitantly with an ICS for at least 3 consecutive mo. Cont-pt has responded to Nucala tx as determined by the prescribing physician AND Pt continues to receive tx with an inhaled corticosteroid. EGPA initial-pt has/had a blood eosinophil level of greater

PA Criteria	Criteria Details
	<p>than or equal to 150 cells per microliter within the previous 6 wks or within 6 wks prior to tx with any anti-interleukin (IL)-5 therapy. Cont-pt has responded to Nucala tx as determined by the prescribing physician. HES initial-pt has had hypereosinophilic syndrome for greater than or equal to 6 mo AND has FIP1L1-PDGFRalpha-negative disease AND the pt does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome AND prior to initiating tx with any anti-interleukin-5 tx, pt has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter. Cont-approve if pt has received at least 8 mo of tx with Nucala (patients who have received less than 8 mo of tx or who are restarting tx should be reviewed under initial tx) and pt has responded to Nucala tx. Nasal polyps, initial-approve if pt meets ALL of the following criteria(A, B, C and D):A) pt has chronic rhinosinusitis with nasal polyposis as evidenced by direct exam, endoscopy, or sinus CT scan AND B)pt has experienced 2 or more of the following symptoms for at least 6 mo: nasal congestion/obstruction/discharge, and/or reduction/loss of smell AND C)pt meets BOTH of the following (a and b): a)Pt has received at least 8 weeks of tx with intranasal corticosteroid AND b)Pt will cont to receive tx with an intranasal corticosteroid concomitantly with Nucala AND D)pt meets 1 of the following (a, b or c): a)Pt has received at least 1 course of tx with a systemic corticosteroid for 5 days or more within the previous 2 yrs, OR b)Pt has a contraindication to systemic corticosteroid therapy, OR c)Pt has had prior surgery for nasal polyps. Cont-approve if pt has received at least 6 mo of tx, continues to receive tx with an intranasal corticosteroid and has responded to tx.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- Nuedexta

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

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NURTEC

Products Affected

- Nurtec ODT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Migraine, Acute treatment-approve. Preventive treatment of episodic migraine-approve if the patient has greater than or equal to 4 but less than 15 migraine headache days per month (prior to initiating a migraine preventive medication and has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NYVEPRIA

Products Affected

- Nyvepria

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if - the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients undergoing PBPC collection and therapy

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial)
Coverage Duration	6 months initial, 1 year cont.
Other Criteria	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OCTREOTIDE INJECTABLE

Products Affected

- octreotide acetate injection solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	BCC - Must not have had disease progression while on Erivedge (vismodegib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Metastatic BCC

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45% of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML - Approve if the patient meets the following criteria (both A and B): A) Following intensive induction chemotherapy, the patient achieves one of the following according to the prescriber (i or ii): i. First complete remission OR ii. First complete remission with incomplete blood count recovery AND B) Patient is not able to complete intensive curative therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orencia ClickJect
- Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	SC-6 mos initial, 1 year cont
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). PsA, initial -approve. Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], initial - approve if the patient has tried one other agent for this condition or the patient will be starting on Orencia concurrently with methotrexate, sulfasalazine or leflunomide or the patient has an absolute contraindication to methotrexate, sulfasalazine or leflunomide or the patient has aggressive disease as determined by the prescribing physician. Cont tx - responded to therapy as per the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Prostate Cancer-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- Orkambi oral granules in packet
- Orkambi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Trikafta or Symdeko.
Required Medical Information	N/A
Age Restrictions	2 years of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORLADEYO

Products Affected

- Orladeyo

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant Use with Other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda, Takhzyro).
Required Medical Information	Diagnosis
Age Restrictions	12 years and older (initial and continuation)
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders. (initial and continuation)
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Prophylaxis, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein at baseline, as defined by the laboratory reference values [documentation required] AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values [documentation required]. Continuation- According to the prescriber the patient has had a favorable clinical response since initiating Orladeyo prophylactic therapy compared with baseline [documentation required to confirm diagnosis of HAE type I or II for continuation].
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous drugs tried
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	All dx-initial only-PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist. Behcet's-prescribed by or in consultation with a dermatologist or rheumatologist
Coverage Duration	6 months initial, 1 year cont
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to step back and try a conventional DMARD first). Behcet's-patient has oral ulcers or other mucocutaneous involvement AND patient has tried at least ONE other systemic therapy. PsA/PP/Behcet's- cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist or an optometrist.
Coverage Duration	2 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PALYNZIQ

Products Affected

- Palynziq subcutaneous syringe 10 mg/0.5 mL, 2.5 mg/0.5 mL, 20 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, phenylalanine concentrations
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year (initial and continuation)
Other Criteria	Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., prior treatment with Kuvan). Maintenance therapy - approve if the patient has experienced improvement while on Palynziq.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist
Coverage Duration	1 year
Other Criteria	Kaposi Sarcoma-approve if the patient is not receiving systemic therapy for Kaposi Sarcoma.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PENICILLAMINE

Products Affected

- penicillamine oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHENYL BUTYRATE

Products Affected

- Ravicti
- sodium phenylbutyrate

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Ravicti and Buphenyl
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
Other Criteria	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHEOCHROMOCYTOMA

Products Affected

- metyrosine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior medication trials
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for metyrosine)
Coverage Duration	Authorization will be for 1 year
Other Criteria	If the requested drug is metyrosine for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Products Affected

- Alyq
- sildenafil (Pulmonary Arterial Hypertension) oral tablet
- tadalafil (pulmonary arterial hypertension) oral tablet 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, right heart cath results
Age Restrictions	N/A
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIQRAY

Products Affected

- Piqray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast Cancer. Approve if the patient meets the following criteria (A, B, C, D, E and F): A) The patient is a postmenopausal female or a male or premenopausal and is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) analog or has had surgical bilateral oophorectomy or ovarian irradiation AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, tamoxifen, toremifene) AND F) Piqray will be used in combination with fulvestrant injection.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Treatment of breast cancer in premenopausal women

PLEGRIDY

Products Affected

- Plegridy subcutaneous pen injector 125 mcg/0.5 mL
- Plegridy subcutaneous syringe 125 mcg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Kaposi Sarcoma/MM-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	CNS Lymphoma-approve if the patient has relapsed or refractory disease. Kaposi Sarcoma-Approve if the patient meets one of the following (i or ii): i. patient is Human Immunodeficiency Virus (HIV)-negative OR ii. patient meets both of the following (a and b): a) The patient is Human Immunodeficiency Virus (HIV)-positive AND b) The patient continues to receive highly active antiretroviral therapy (HAART). MM-approve if the patient has received at least one other Revlimid (lenalidomide tablets)-containing regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Systemic Light Chain Amyloidosis, Central Nervous System (CNS) Lymphoma

POSACONAZOLE (ORAL)

Products Affected

- Noxafil oral suspension
- posaconazole oral tablet, delayed release (DR/EC)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Aspergillus/Candida prophylaxis, mucormycosis-6 mo, all others-3 months
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	esophageal candidiasis - treatment, mucormycosis - maintenance, fusariosis, invasive - treatment fungal infections (systemic) in patients with human immunodeficiency virus (HIV) infections (e.g., histoplasmosis, coccidioidomycosis) - treatment.

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.
Other Criteria	<p>Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture . Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer, approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole,</p>

PA Criteria	Criteria Details
	exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
Age Restrictions	N/A
Prescriber Restrictions	Immune Thrombocytopenia or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist (initial therapy). Thrombocytopenia in pt with chronic Hep C, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease (initial therapy). MDS-presc or after consult with heme/onc (initial therapy).
Coverage Duration	Immune Thrombo/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr
Other Criteria	Thrombocytopenia in patients with immune thrombocytopenia, initial-approve if the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and the patient is at an increased risk for bleeding AND the patient has tried ONE other therapy or has undergone a splenectomy. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications. Treatment of thrombocytopenia in patients with Chronic Hepatitis C initial-approve if the patient will be receiving interferon-based therapy for chronic hepatitis C AND to allow for initiation of antiviral therapy if the patient has low platelet counts at baseline (eg, less than 75,000 microliters). Aplastic anemia initial - approve if the patient has low platelet counts at baseline/pretreatment (e.g., less than 30,000 microliters) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy. Cont-approve if the patient demonstrates a beneficial clinical response. MDS initial-approve if patient has low- to intermediate-risk MDS AND the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and is at an increased risk

PA Criteria	Criteria Details
	for bleeding. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Thrombocytopenia in Myelodysplastic Syndrome (MDS)

PYRIMETHAMINE

Products Affected

- pyrimethamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient's immune status
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Gastrointestinal stromal tumor (GIST), advanced-approve if, according to labeling, the patient has been previously treated with imatinib and at least two other kinase inhibitors, in addition to imatinib.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid or Praluent.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Approve for 1 year
Other Criteria	<p>Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation.</p> <p>Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or</p>

PA Criteria	Criteria Details
	higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RETEVMO

Products Affected

- Retevmo oral capsule 40 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Medullary Thyroid Cancer/Thyroid Cancer-12 years and older, all others 18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is RET fusion-positive. Medullary Thyroid Cancer-approve if the patient has advanced or metastatic RET-mutant disease and the disease requires treatment with systemic therapy. Thyroid Cancer-approve if the patient has advanced or metastatic RET fusion positive disease, the disease is radioactive iodine-refractory (if radioactive iodine is appropriate) and the disease requires treatment with systemic therapy. Anaplastic thyroid cancer-approve if the patient has RET fusion-positive anaplastic thyroid carcinoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anaplastic thyroid carcinoma

REVCovi

Products Affected

- Revcovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab values, genetic tests
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with, an immunologist, hematologist/oncologist, or physician that specializes in ADA-SCID or related disorders.
Coverage Duration	12 months
Other Criteria	ADA-SCID - approve if the patient had absent or very low (less than 1% of normal) ADA catalytic activity at baseline (i.e., prior to initiating enzyme replacement therapy) OR if the patient had molecular genetic testing confirming bi-allelic mutations in the ADA gene
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REVLIMID

Products Affected

- lenalidomide
- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	18 years and older (except Kaposi's Sarcoma, Castleman's Disease, CNS Lymphoma)
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	<p>Follicular lymphoma-approve if the patient is using Revlimid in combination with rituximab or has tried at least on prior therapy. MCL-approve if the patient is using revlimid in combination with rituximab or has tried at least two other therapies or therapeutic regimens. MZL-approve if the patient is using revlimid in combination with rituximab or has tried at least one other therapy or therapeutic regimen. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). B-cell-lymphoma (other)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia and the pt has serum erythropoietin levels greater than or equal to 500 mU/ml or according to the prescriber the patient has anemia, has serum erythropoietin levels less than 500 mU/mL and patient has experienced no response or loss of response to erythropoietic stimulating agents. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS lymphoma-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient tried at least one other therapy or therapeutic</p>

PA Criteria	Criteria Details
	regimen. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease. Systemic light chain amyloidosis-approve if Revlimid is used in combination with dexamethasone.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis. Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system lymphoma, Kaposi's sarcoma.

RILUZOLE

Products Affected

- riluzole

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RINVOQ

Products Affected

- Rinvoq oral tablet extended release 24 hr
15 mg, 30 mg, 45 mg

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	PsA/RA/UC/AS-18 years and older (initial therapy), AD-12 years and older (Initial therapy)
Prescriber Restrictions	RA/AS, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. AD-prescr/consult with allergist, immunologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Authorization will be for 6 months initial, 1 year cont.
Other Criteria	RA/PsA/UC/AS initial-approve if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AD-approve if the patient has had a 3 month trial of at least one traditional systemic therapy or has tried at least one traditional systemic therapy but was unable to tolerate a 3 month trial. Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ROZLYTREK

Products Affected

- Rozlytrek oral capsule 100 mg, 200 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Solid Tumors-12 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor AND B) The patient's tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND C) The patient meets one of the following criteria (i or ii): i. The patient has progressed on prior therapies OR ii. There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3years
Other Criteria	Ovarian, Fallopian Tube or Primary Peritoneal Cancer-treatment-Approve if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy. Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer-Approve if the patient is in complete or partial response after at least two platinum-based chemotherapy regimens. Castration-Resistant Prostate Cancer - Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has metastatic disease that is BRCA-mutation positive (germline and/or somatic) AND B) The patient meets one of the following criteria (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy AND C) The patient has been previously treated with at least one androgen receptor-directed therapy AND D) The patient meets one of the following criteria (i or ii): i. The patient has been previously treated with at least one taxane-based chemotherapy OR ii. The patient is not a candidate or is intolerant to taxane-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RUFINAMIDE

Products Affected

- rufinamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Patients 1 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Initial therapy-approve if rufinamide is being used for adjunctive treatment. Continuation-approve if the patient is responding to therapy
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Treatment-Refractory Seizures/Epilepsy

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For AML, FLT3 status
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML (for PDP enrollees) -approve if the patient is FLT3-mutation positive as detected by an approved test. AML (for MAPD enrollees) -approve if the patient is FLT3-mutation positive as detected by an approved test AND the patient is receiving Rydapt in one of the following settings (i, ii, iii, or iv)-i. Induction therapy in combination with cytarabine and daunorubicin OR ii. After standard-dose cytarabine induction/reinduction, along with cytarabine and daunorubicin OR iii. Post remission or consolidation therapy in combination with cytarabine OR iv. Maintenance therapy. Myeloid or lymphoid Neoplasms with eosinophilia-approve if the patient has an FGFR1 rearrangement or has an FLT3 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid or lymphoid Neoplasms with eosinophilia

SAPROPTERIN

Products Affected

- sapropterin

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Palynziq (continuation only)
Required Medical Information	Diagnosis, Phe concentration
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
Coverage Duration	Initial-12 weeks, Continuation-1 year
Other Criteria	Initial - approve. Continuation - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20 percent or greater reduction in blood Phe concentration from baseline OR treatment with sapropterin has resulted in an increase in dietary phenylalanine tolerance.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SCSEMBLIX

Products Affected

- Scemblix oral tablet 20 mg, 40 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Chronic Myeloid Leukemia (CML)-approve if the patient meets the following (A and B): A) Patient has Philadelphia chromosome-positive chronic myeloid leukemia, AND B) Patient meets one of the following (i or ii): i. The chronic myeloid leukemia is T315I-positive, OR ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia. Note: Examples of tyrosine kinase inhibitors include imatinib tablets, Bosulif (bosutinib tablets), Iclusig (ponatinib tablets), Sprycel (dasatinib tablets), and Tasigna (nilotinib capsules).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SENSIPAR

Products Affected

- cinacalcet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Hypercalcemia d/t parathyroid CA-prescr/consult w/onco or endo. Hypercalcemia w/primary hyperparathyroidism-prescr/consult w/nephro or endo. Hyperparathyroidism in post-renal transplant-prescr/consult w/transplant physician/nephro/endo.
Coverage Duration	12 months
Other Criteria	Hypercalcemia due to parathyroid carcinoma-approve. Hypercalcemia in patients with primary hyperparathyroidism-approve if the patient has failed or is unable to undergo a parathyroidectomy due to a contraindication. Secondary Hyperparathyroidism in patients with chronic kidney disease on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundles payment benefit). Hyperparathyroidism in Post-Renal Transplant Patients-approve if the baseline (prior to starting cinacalcet therapy) calcium and intact parathyroid hormone (iPTH) levels are above the normal range, as defined by the laboratory reference values.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	hyperparathyroidism in post-renal transplant patients

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
Coverage Duration	Cushing's disease/synd-Initial-4 mo,Cont-1 yr. Pt awaiting surgery/response after radiotherapy-4 mo
Other Criteria	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Exclusion Criteria	Patients weighing less than 15 kg
Required Medical Information	Diagnosis, concomitant therapy
Age Restrictions	Patients 5 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with an infectious diseases specialist
Coverage Duration	9 months
Other Criteria	Tuberculosis, Pulmonary Multidrug-resistant or extensively drug resistant-prescribed as part of a combination regimen with other anti-tuberculosis agents
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- Skyrizi subcutaneous pen injector
- Skyrizi subcutaneous syringe kit
- Skyrizi subcutaneous syringe 150 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older (initial therapy)
Prescriber Restrictions	PP-Prescribed by or in consultation with a dermatologist (initial therapy), PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy), CD-presc/consult-gastro
Coverage Duration	6 mos initial, 1 year cont
Other Criteria	Under CMS Review.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOLARAZE

Products Affected

- diclofenac sodium topical gel 3 %

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

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 year
Other Criteria	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SPRYCEL

Products Affected

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	GIST-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - approve if the patient has tried at least two other therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	GIST, chondrosarcoma, chordoma

STELARA

Products Affected

- Stelara subcutaneous solution
- Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	18 years and older CD/UC (initial therapy). PP-6 years and older (initial therapy).
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist (initial therapy). PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD/UC-prescribed by or in consultation with a gastroenterologist (initial therapy).
Coverage Duration	PP/PsA Init-6mo,CD/UC load-approve 1 dose IV,CD/UC post IV load-SC 6 mo,cont tx-SC 1 yr
Other Criteria	PP initial - Approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab) OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. CD, initial therapy (only after receiving single IV loading dose within 2 months of initiating therapy with Stelara SC) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.PP initial - approve Stelara SC. CD, initial therapy - approve 3 months of the SC formulation if the

PA Criteria	Criteria Details
	<p>patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). For HCC, patient must have previously been treated with at least one tyrosine kinase inhibitor (e.g., Nexavar, Lenvima). Soft tissue sarcoma-approve if the patient has non-adipocytic extremity/superficial trunk, head/neck or retroperitoneal/intra-abdominal sarcoma OR pleomorphic rhabdomyosarcoma. Osteosarcoma-approve if the patient has relapsed/refractory or metastatic disease and the requested medication is being used as subsequent therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue Sarcoma, Osteosarcoma

SUCRAID

Products Affected

- Sucraid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, genetic and lab test results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SUTENT

Products Affected

- sunitinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST), approve if the patient tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy or radiation therapy. Renal Cell Carcinoma (RCC), clear cell or non-clear cell histology-approve if the patient is at high risk of recurrent clear cell RCC following nephrectomy and Sutent is used for adjuvant therapy or if the patient has relapsed or Stage IV disease. Neuroendocrine tumors of the pancreas-approve for advanced or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, meningioma, thymic carcinoma.

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	Patients with unknown CFTR gene mutations, Combination therapy with Orkambi, Kalydeco or Trikafta
Required Medical Information	Diagnosis, specific CFTR gene mutations
Age Restrictions	Six years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must be homozygous for the F508del mutation or have at least one mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SYMLIN

Products Affected

- SymlinPen 120
- SymlinPen 60

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SYNAREL

Products Affected

- Synarel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Endometriosis-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Central Precocious Puberty-12 months, Endometriosis-6 months
Other Criteria	Central precocious puberty-approve. Endometriosis-approve if the patient has tried one of the following, unless contraindicated, a contraceptive, an oral progesterone or a depo-medroxyprogesterone injection. Note: An exception to the requirement for a trial of the above therapies can be made if the patient has previously used a gonadotropin-releasing hormone (GnRH) agonist or antagonist for endometriosis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is positive for a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping or high-level MET amplification, as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-small cell lung cancer with high-level MET amplification.

TAFAMIDIS

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with Onpattro or Tegsedi. Concurrent use of Vyndaqel and Vyndamax.
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
Coverage Duration	1 year
Other Criteria	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis-approve if the diagnosis was confirmed by one of the following (i, ii or iii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy), ii. Amyloid deposits are identified on cardiac biopsy OR iii. patient had genetic testing which, according to the prescriber, identified a TTR mutation AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Mekinist. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of pilocytic astrocytoma OR pleomorphic xanthoastrocytoma OR ganglioglioma, OR ii) recurrent disease for one of the following: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following: multisystem disease OR pulmonary disease OR

PA Criteria	Criteria Details
	central nervous system lesions OR patient has Erdheim Chester disease AND patient has BRAF V600-mutation positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Differentiated Thyroid Cancer, Biliary tract cancer, central nervous system cancer, histiocytic neoplasm

TAGRISO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC-EGFR Mutation Positive (other than EGFR T790M-Positive Mutation)- approve if the patient has advanced or metastatic disease, has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note-examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681. NSCLC-EGFR T790M mutation positive-approve if the patient has metastatic EGFR T790M mutation-positive NSCLC as detected by an approved test and has progressed on treatment with at least one of the EGFR tyrosine kinase inhibitors. NSCLC-Post resection-approve if the patient has received previous adjuvant chemotherapy or if the patient is ineligible to receive platinum based chemotherapy and the patient has EGFR exon 19 deletions or exon 21 L858R substitution mutations, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALTZ

Products Affected

- Taltz Autoinjector
- Taltz Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	PP-6 years and older (initial therapy), all other dx-18 years of age and older (initial therapy)
Prescriber Restrictions	All dx initial therapy only-PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. AS/spondylo -prescribed by or in consultation with a rheum.
Coverage Duration	Initial authorization will be for 6 months, 1 year continuation.
Other Criteria	Initial Therapy - Plaque Psoriasis-approve if the patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR the patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician. An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic. PsA Initial-Approve. AS initial-approve. Non-Radiographic Axial Spondyloarthritis-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory or sacroiliitis reported on magnetic resonance imaging. Continuation Therapy - approve if the patient has responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALZENNA

Products Affected

- Talzenna oral capsule 0.25 mg, 0.5 mg, 0.75 mg, 1 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRCA mutation status, HER2 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally-advanced or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive AND human epidermal growth factor receptor 2 (HER2) negative disease
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TARGRETIN TOPICAL

Products Affected

- Targretin topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TASIGNA

Products Affected

- Tasigna oral capsule 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
Age Restrictions	ALL/GIST-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO or more therapies. For ALL, Approve if the patient has tried one other tyrosine kinase inhibitor that is used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).

TAZAROTENE

Products Affected

- tazarotene topical cream
- Tazorac topical gel
- Tazorac topical cream 0.05 %

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic uses
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	Epithelioid Sarcoma-16 years and older, Follicular Lymphoma-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Epithelioid Sarcoma-approve if the patient has metastatic or locally advanced disease and the patient is not eligible for complete resection. Follicular Lymphoma-approve if the patient has relapsed or refractory disease and according to the prescriber, there are no appropriate alternative therapies or the patient's tumor is positive for an EZH2 mutation and the patient has tried at least two prior systemic therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutations or patient has high-level MET amplification, as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-small cell lung cancer with high-level MET amplification.

TERIPARATIDE

Products Affected

- teriparatide

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture. Patients who

PA Criteria	Criteria Details
	have already taken teriparatide for 2 years - approve if the patient is at high risk for fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TETRABENAZINE

Products Affected

- tetrabenazine oral tablet 12.5 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	MM, myelofibrosis-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve. Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried at least two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if according to the prescriber the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/mL or if the patient has serum erythropoietin level less than 500 mU/mL and experienced no response or loss of response to erythropoietic stimulating agents. Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried at least two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease. Castleman's disease-approve if the patient has multicentric Castleman's disease, and is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Kaposi's Sarcoma, Castleman's Disease.

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, IDH1 Status
Age Restrictions	All diagnoses (except chondrosarcoma)-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test. Cholangiocarcinoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive and has been previously treated with at least one chemotherapy regimen (chemotherapy requirement only applies to beneficiaries enrolled in an MA-PD plan). Chondrosarcoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chondrosarcoma

TOLVAPTAN

Products Affected

- Samsca oral tablet 15 mg
- tolvaptan

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Jynarque.
Required Medical Information	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 30 days
Other Criteria	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on tolvaptan and has received less than 30 days of therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPICAL AGENTS FOR ATOPIC DERMATITIS

Products Affected

- pimecrolimus
- tacrolimus topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL RETINOID PRODUCTS

Products Affected

- Avita topical cream
- tretinoin topical

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPIRAMATE/ZONISAMIDE

Products Affected

- Eprontia
- topiramate oral capsule, sprinkle
- topiramate oral tablet
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRANSDERMAL FENTANYL

Products Affected

- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRANSMUCOSAL FENTANYL DRUGS

Products Affected

- fentanyl citrate buccal lozenge on a handle

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRIENTINE

Products Affected

- trientine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medication history, pregnancy status, disease manifestations
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	Authorization will be for 1 year
Other Criteria	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant, OR 6) the patient has been started on therapy with trientine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
Required Medical Information	Diagnosis, specific CFTR gene mutations, concurrent medications
Age Restrictions	Six years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRUSELTIQ

Products Affected

- Truseltiq oral capsule 100 mg/day (100 mg x 1), 125 mg/day (100 mg x 1-25mg x 1), 50 mg/day (25 mg x 2), 75 mg/day (25 mg x 3)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease, has fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test and Truseltiq will be used as subsequent therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TUKYSA

Products Affected

- Tukysa oral tablet 150 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Breast Cancer-approve if the patient has advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive disease, has received at least one prior anti-HER2-based regimen in the metastatic setting and Tukysa is used in combination with trastuzumab and capecitabine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)-approve if, according to the prescriber, the tumor is not amenable to improvement with surgery. Histiocytic Neoplasms-approve if the patient has a colony stimulating factor 1 receptor (CSF1R) mutation AND has one of the following conditions (i, ii, or iii): i. Langerhans cell histiocytosis OR ii. Erdheim-Chester disease OR iii. Rosai-Dorfman disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Histiocytic Neoplasms

UBRELVY

Products Affected

- Ubrelyvy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Migraine, Acute treatment-approve
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UPTRAVI

Products Affected

- Uptravi oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmation of right heart catheterization, medication history.
Age Restrictions	N/A
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to therapy must meet a) OR b): a) tried one or is currently taking one oral therapy for PAH for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Cutaneous Lymphomas (Note-includes mycosis fungoides/Sezary syndrome, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders)-approve. Adult T-Cell Leukemia/Lymphoma-approve if the patient has chronic/smoldering subtype of adult T-cell leukemia/lymphoma. Langerhans cell histiocytosis-approve if the patient has unifocal Langerhans cell histiocytosis with isolated skin disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Adults with T-cell leukemia/lymphoma, Langerhans Cell Histiocytosis

VALTOCO

Products Affected

- Valtoco

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other medications used at the same time
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VANCOMYCIN

Products Affected

- vancomycin oral capsule 125 mg, 250 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 weeks
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VENCLEXTA

Products Affected

- Venclexta oral tablet 10 mg, 100 mg, 50 mg
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL with or without 17p deletion - approve. SLL-approve. Mantle Cell Lymphoma-approve if the patient has tried one prior therapy. AML-approve if the patient is using Venclexta in combination with either azacitidine, decitabine, or cytarabine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Mantle Cell Lymphoma

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Breast cancer, early-approve for 2 years, all other-3 years
Other Criteria	<p>Breast Cancer, Early-Approve if pt meets (A,B,C and D): A)Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets the following:Pt has node-positive disease at high risk of recurrence (Note-High risk includes patients with greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease, tumor size greater than or equal to 5 cm, or a Ki-67 score of greater than or equal to 20%) AND D)Pt meets ONE of the following (i or ii): i.Verzenio will be used in combo w/anastrozole, exemestane, or letrozole AND pt meets one of the following (a,b, or c): a)Pt is a postmenopausal woman, OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, OR 2-Pt has had surgical bilateral oophorectomy or ovarian irradiation, OR c)Pt is a man and pt is receiving a GnRH analog, OR ii.Verzenio will be used in combo with tamoxifen AND pt meets one of the following (a or b): a)Pt is a postmenopausal woman or man OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR 2-Patient has had surgical bilateral oophorectomy or ovarian irradiation. Breast Cancer-Advanced or Metastatic in Women-Approve if pt meets (A, B, C and D): A) Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets ONE of the following criteria (i or ii): i.Pt is a</p>

PA Criteria	Criteria Details
	<p>postmenopausal woman, OR ii. Pt is a pre/perimenopausal woman and meets one of the following (a or b): a) Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR b) Pt has had surgical bilateral oophorectomy or ovarian irradiation, AND D) Pt meets ONE of the following criteria (i, ii, or iii): i. Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii. Verzenio will be used in combo with fulvestrant, OR iii. pt meets the following conditions (a, b, and c): a) Verzenio will be used as monotherapy, AND b) Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c) Pt has tried chemotherapy for metastatic breast cancer. Breast Cancer-Advanced or Metastatic in Men-Approve if pt meets the following criteria (A,B and C): A) Pt has HR+ disease, AND B) Pt has HER2-negative breast cancer, AND C) Pt meets ONE of the following criteria (i, ii, or iii): i. Pt meets BOTH of the following conditions (a and b): a) Pt is receiving a GnRH analog, AND b) Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii. Verzenio will be used in combo with fulvestrant, OR iii. Pt meets the following conditions (a, b, and c): a) Verzenio will be used as monotherapy, AND b) Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c) Pt has tried chemotherapy for metastatic breast cancer.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VITRAKVI

Products Affected

- Vitrakvi oral capsule 100 mg, 25 mg
- Vitrakvi oral solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, NTRK gene fusion status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, EGFR status, exon deletions or substitutions
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has advanced or metastatic disease and has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including primary MF, post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate risk or high risk disease and the patient has a platelet count of less than $50 \times 10^9/L$ (less than 50,000/mcL)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VORICONAZOLE (ORAL)

Products Affected

- voriconazole

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Aspergillus-Prophy, systemic w/risk neutropenia-Prophy, systemic w/HIV-Prophy/Tx-6 mo, others-3 mo
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Aspergillus Infections - prophylaxis, oropharyngeal candidiasis (fluconazole-refractory) - treatment, candidia endophthalmitis - treatment, blastomycosis - treatment, fungal infections (systemic) in patients at risk of neutropenia - prophylaxis, fungal infections (systemic) in patients with human immunodeficiency virus (HIV) - prophylaxis or treatment.

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma, or solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has recurrent, advanced or metastatic disease. Advanced Renal Cell Carcinoma, Clear Cell or non-Clear Cell histology-approved if the patient has relapsed or stage IV disease. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary thyroid carcinoma.

VUMERITY

Products Affected

- Vumerity

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Van Hippel-Lindau Disease-approve if the patient meets the following (A, B, and C): A) Patient has a von Hippel-Lindau (VHL) germline alteration as detected by genetic testing, B) Does not require immediate surgery and C) Patient requires therapy for ONE of the following conditions (i, ii, iii, or iv): i. Central nervous system hemangioblastomas, OR ii. Pancreatic neuroendocrine tumors, OR iii. Renal cell carcinoma, OR iv. Retinal hemangioblastoma.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	ALK status, high level MET amplification status, MET Exon 14 skipping mutation, and ROS1. For soft tissue sarcoma IMT, ALK translocation.
Age Restrictions	Anaplastic large cell lymphoma-patients greater than or equal to 1 year of age and less than 21 years of age
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC, recurrent or metastatic disease-approve if the patient meets one of the following: must be ALK-positive as detected by an approved test, or have high level MET amplification or have MET Exon 14 skipping mutation or have ROS1 rearrangement as detected by an approved test. Anaplastic Large Cell Lymphoma-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease AND has received at least one prior systemic treatment. Histiocytic neoplasm-approve if the patient has ALK rearrangement/fusion-positive disease and meets one of the following criteria (i, ii, or iii): (i. Patient has Langerhans cell histiocytosis, OR ii. Patient has Erdheim-Chester disease OR iii. Patient has Rosai-Dorfman disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, NSCLC with high level MET amplification or MET Exon 14 skipping mutation, Histiocytic neoplasms.

XELJANZ

Products Affected

- Xeljanz oral solution
- Xeljanz oral tablet
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a Targeted Synthetic DMARD for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA/JRA/AS-prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	PsA/RA/JIA/JRA/AS/UC-6 months initial, All diagnoses-1 year cont.
Other Criteria	RA initial-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. PsA initial, approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial and the requested medication will be used in combination with methotrexate or another conventional synthetic disease modifying antirheumatic drug (DMARD), unless contraindicated. UC- Approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least ONE tumor necrosis factor inhibitor for ulcerative colitis or was unable to tolerate a 3-month trial. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis]-initial-approve Xeljanz immediate release tablets or solution if the patient meets the following: patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AS-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least

PA Criteria	Criteria Details
	one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]) AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair subcutaneous recon soln
- Xolair subcutaneous syringe 150 mg/mL, 75 mg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
Required Medical Information	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). CIU - must have urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).
Age Restrictions	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older.
Prescriber Restrictions	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist. Polyps-prescribed by or in consult with an allergist, immunologist, or otolaryngologist.
Coverage Duration	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months
Other Criteria	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring

PA Criteria	Criteria Details
	<p>hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - must have responded to therapy as determined by the prescribing physician. Nasal Polyps Initial-Approve if the patient has a baseline IgE level greater than or equal to 30 IU/ml, patient is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell and patient is currently receiving therapy with an intranasal corticosteroid. Nasal polyps continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid and has responded to therapy.</p>
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, FLT3-mutation status
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test. Lymphoid, Myeloid, or Mixed Lineage Neoplasms-approve if the patient has eosinophilia and the disease is FLT3-mutation positive as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Lymphoid, Myeloid, or Mixed Lineage Neoplasms

XPOVIO

Products Affected

- Xpovio oral tablet 100 mg/week (50 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 80mg twice week (80 mg x 2), 160mg twice week (160 mg/week)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Multiple Myeloma-Approve if the patient meets the following (A and B): A) The medication will be taken in combination with dexamethasone AND B) Patient meets one of the following (i, ii, or iii): i. Patient has tried at least four prior regimens for multiple myeloma OR ii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with bortezomib OR iii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with Darzalex (daratumumab infusion), Darzalex Faspro (daratumumab and hyaluronidase-fihj injection), or Pomalyst (pomalidomide capsules). Note: Examples of regimens for multiple myeloma include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib infusion)/Revlimid/dexamethasone, Darzalex (daratumumab injection)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. Diffuse large B-cell lymphoma-approve if the patient has been treated with at least two prior systemic therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Treatment of multiple myeloma in combination with daratumumb or pomalidomide

XTANDI

Products Affected

- Xtandi oral capsule
- Xtandi oral tablet 40 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Xtandi is being used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate cancer-castration-resistant (CRPC) [Metastatic or Non-metastatic] and Prostate cancer-metastatic, castration sensitive-approve if Xtandi will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic specialist, geneticist or physician specializing in the condition being treated
Coverage Duration	1 year
Other Criteria	Hereditary orotic aciduria (Orotic aciduria Type 1)-Approve if the patient has molecular genetic testing confirming mutation in the UMPS gene or clinical diagnosis supported by first degree family relative (i.e., parent or sibling) with hereditary orotic aciduria and urinary orotic acid level above the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a sleep specialist physician or a Neurologist
Coverage Duration	12 months.
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexamethylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy- approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone and the patient meets ONE of the following criteria (i or ii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6mo.HIV/AIDS-4mo.MDS-3mo.PBPC,Drug induce A/N,AA,ALL,BMT- 3mo. Radi-1mo.other-12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgramstim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia

PA Criteria	Criteria Details
	[absolute neutrophil account less than 100 cells/mm ³], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - approve if the patient is in complete or partial response after platinum-based chemotherapy regimen. Ovarian, fallopian tube, or primary peritoneal cancer, treatment-approve per label if the patient has tried at least three prior chemotherapy regimens and has homologous recombination deficiency (HRD)-positive disease as confirmed by an approved test. Uterine leiomyosarcoma-approve if the patient has BRCA2 mutation and has tried one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Uterine Leiomyosarcoma

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	BRAFV600 mutation status required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresectable, advanced or metastatic melanoma. HCL - must have tried at least one other systemic therapy for hairy cell leukemia. Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy. Erdheim-Chester disease, in patients with the BRAF V600 mutation-approve. Central Nervous System Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of pilocytic astrocytoma OR pleomorphic xanthoastrocytoma OR ganglioglioma, OR ii) recurrent disease for one of the following conditions: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND the medication will be taken in combination with Cotellic (cobimetinib tablets). Histiocytic Neoplasm-approve if the patient has Langerhans cell histiocytosis and one of the following: multisystem disease OR pulmonary disease OR central nervous system lesions AND the patient has BRAF V600-mutation positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease, Central Nervous System Cancer, Histiocytic Neoplasm

ZEPOSIA

Products Affected

- Zeposia
- Zeposia Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Exclusion Criteria	MS-Concurrent use with other disease-modifying agents used for multiple sclerosis.UC- Concurrent Use with a Biologic or with a Targeted Synthetic Disease-modifying Antirheumatic Drug (DMARD) for Ulcerative Colitis
Required Medical Information	Diagnosis
Age Restrictions	UC-18 years and older
Prescriber Restrictions	MS-Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis. UC-Prescribed by or in consultation with a gastroenterologist
Coverage Duration	1 year
Other Criteria	Ulcerative Colitis, initial-approve if the patient has tried Humira (a trial of Simponi SC or infliximab would also count) AND Stelara (a trial of Entyvio or Stelara IV would also count). Cont tx-approve if the patient has been established on Zeposia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZIEXTENZO

Products Affected

- Ziextenzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation.
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if-the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients undergoing PBPC collection and therapy

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CLL-approve if the patient has tried two prior therapies. Marginal Zone Lymphoma/Follicular Lymphoma/SLL - approve if the patient has tried two prior therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Marginal Zone Lymphoma

ZYKADIA

Products Affected

- Zykadia oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Rearrangement. IMT - ALK Translocation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Patients with NSCLC with ROS1 Rearrangement-First-line therapy.

ZYTIGA

Products Affected

- abiraterone oral tablet 250 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC)-Approve if abiraterone is being used in combination with prednisone or dexamethasone and the medication is used concurrently used with a gonadotropin-releasing hormone (GnRH) analog or the medication is concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate cancer-metastatic, castration-sensitive (mCSPC)-approve if the medication is used in combination with prednisone and the medication is concurrently used with a gonadotropin-releasing hormone analog or concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate Cancer - Regional Risk Group - Approve if the patient meets all of the following criteria (A, B, and C): A)abiraterone is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i, ii or iii): i.abiraterone with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) analog OR ii. Patient has had an orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-very-high-risk-group-approve if according to the prescriber the patient is in the very-high-risk group, the medication will be used in combination with external beam radiation therapy and the patient meets one of the following criteria (i, ii or iii): i. abiraterone is used in combination with gonadotropin-releasing hormone

PA Criteria	Criteria Details
	(GnRH) analog OR ii. Patient has had an orchiectomy OR iii. the medication is used in combination with Firmagon.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Prostate Cancer-Regional Risk Group, Prostate cancer-very-high-risk group

PART B VERSUS PART D

Products Affected

- Abelcet
- acetylcysteine
- Actimmune
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL
- AmBisome
- amphotericin B
- aprepitant
- arformoterol
- azathioprine oral tablet 50 mg
- budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- Clinimix 5%/D15W Sulfite Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfite Free
- Clinimix 5% -D20W(sulfite-free)
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclophosphamide oral tablet
- cyclosporine modified
- cyclosporine oral capsule
- dronabinol
- Emend oral suspension for reconstitution
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF)
- Envarsus XR
- everolimus (immunosuppressive)
- Firmagon kit w diluent syringe
- formoterol fumarate
- Gengraf
- granisetron HCl oral
- Intralipid intravenous emulsion 20 %
- Intron A injection recon soln
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl
- methotrexate sodium
- methotrexate sodium (PF) injection solution
- methylprednisolone oral tablet
- mycophenolate mofetil
- mycophenolate sodium
- ondansetron
- ondansetron HCl oral solution
- ondansetron HCl oral tablet 4 mg, 8 mg
- pentamidine inhalation
- Plenamine
- Prehevbrio (PF)
- Premasol 10 %
- Prograf oral granules in packet
- Pulmozyme
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Sandimmune oral solution
- sirolimus
- Synribo
- tacrolimus oral
- tobramycin in 0.225 % NaCl
- tobramycin inhalation
- Travasol 10 %
- Trelstar intramuscular suspension for reconstitution
- TrophAmine 10 %
- Varubi
- Xatmep
- Xgeva
- Zortress oral tablet 1 mg

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 293
 abiraterone oral tablet 250 mg, 500 mg . 291, 292
 acetylcysteine 293
 Actemra ACTPen..... 1, 2
 Actemra subcutaneous 1, 2
 Actimmune..... 293
 acyclovir sodium intravenous solution ... 293
 acyclovir topical ointment..... 3
 Adbry 4
 Adempas 5
 Afinitor Disperz 72, 73
 Afinitor oral tablet 10 mg 72, 73
 Aimovig Autoinjector 6
 Ajovy Autoinjector 7
 Ajovy Syringe 7
 albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL..... 293
 Alecensa 8
 alosetron..... 130
 Alunbrig oral tablet 180 mg, 30 mg, 90 mg 10
 Alunbrig oral tablets,dose pack..... 10
 Alyq..... 184
 Amabelz 98
 AmBisome 293
 ambrisentan 26
 amikacin injection solution 500 mg/2 mL 12, 13
 amphotericin B..... 293
 ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg 12, 13
 ampicillin-sulbactam injection..... 12, 13
 Androderm 156, 157
 aprepitant..... 293
 Arcalyst 15
 arformoterol 293
 Arikayce..... 16
 armodafinil 140
 Aubagio..... 17
 Avita topical cream 244

Avonex intramuscular pen injector kit..... 18
 Avonex intramuscular syringe kit 18
 Ayvakit..... 19
 azathioprine oral tablet 50 mg..... 293
 azithromycin intravenous..... 12, 13
 aztreonam 12, 13

B

Bafiertam..... 20
 Balversa..... 21
 Belbuca 126, 127
 Benlysta subcutaneous 22
 benztropine oral 94
 Besremi 23
 Betaseron subcutaneous kit..... 24
 bexarotene oral..... 25
 Bicillin C-R..... 12, 13
 Bicillin L-A..... 12, 13
 bosentan 26
 Bosulif oral tablet 100 mg, 400 mg, 500 mg 27
 Braftovi oral capsule 75 mg..... 28
 Brukinsa 29
 budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL..... 293
 buprenorphine transdermal patch.... 126, 127
 Bydureon BCise 86
 Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL 86

C

Cablivi injection kit..... 31
 Cabometyx 32
 Calquence..... 33
 Caprelsa oral tablet 100 mg, 300 mg 34
 Carbaglu..... 35
 carglumic acid..... 35
 Cayston 36
 cefoxitin 12, 13
 ceftazidime..... 12, 13
 cefuroxime sodium injection recon soln 750 mg 12, 13
 cefuroxime sodium intravenous recon soln 1.5 gram 12, 13

Cerdelga	37
Chemet	38
Chenodal	39
Cholbam oral capsule 250 mg, 50 mg	40
Cibinqo.....	41, 42
Cimzia	43, 44
Cimzia Powder for Reconst	43, 44
cinacalcet.....	209
Cinryze.....	30
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 mL	12, 13
clindamycin in 5 % dextrose.....	12, 13
clindamycin phosphate injection.....	12, 13
clindamycin phosphate intravenous solution 600 mg/4 mL.....	12, 13
Clinimix 5%/D15W Sulfite Free	293
Clinimix 4.25%/D10W Sulf Free	293
Clinimix 4.25%/D5W Sulfite Free	293
Clinimix 5%-D20W(sulfite-free).....	293
clobazam oral suspension	45
clobazam oral tablet	45
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	93
colistin (colistimethate Na)	12, 13
Cometriq oral capsule 100 mg/day(80 mg x1-20 mg x1), 140 mg/day(80 mg x1-20 mg x3), 60 mg/day (20 mg x 3/day)	46
Cotellic.....	47
Cresemba oral	48
Crinone vaginal gel 8 %	49
cromolyn inhalation	293
cyclobenzaprine oral tablet 10 mg, 5 mg..	95
cyclophosphamide oral capsule	293
cyclophosphamide oral tablet	293
cyclosporine modified.....	293
cyclosporine oral capsule	293
Cystagon	51
Cystaran	50
D	
dalfampridine	52
Daliresp	53
Daurismo oral tablet 100 mg, 25 mg	54
deferasirox.....	55
deferiprone	56
Diacomit.....	57
Diazepam Intensol	93

diazepam oral solution 5 mg/5 mL (1 mg/mL)	93
diazepam oral tablet	93
diclofenac sodium topical gel 3 %	213
dimethyl fumarate oral capsule, delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg.....	58
Doptelet (10 tab pack).....	59
Doptelet (15 tab pack).....	59
Doptelet (30 tab pack).....	59
Dotti	98
Doxy-100	12, 13
dronabinol	293
droxidopa	158
Dupixent Pen subcutaneous pen injector 200 mg/1.14 mL, 300 mg/2 mL	60, 61
Dupixent Syringe subcutaneous syringe 100 mg/0.67 mL, 200 mg/1.14 mL, 300 mg/2 mL.....	60, 61
E	
Emend oral suspension for reconstitution	293
Emgality Pen.....	62
Emgality Syringe subcutaneous syringe 120 mg/mL.....	62
Enbrel Mini	63, 64
Enbrel subcutaneous recon soln.....	63, 64
Enbrel subcutaneous solution	63, 64
Enbrel subcutaneous syringe.....	63, 64
Enbrel SureClick.....	63, 64
Engerix-B (PF) intramuscular syringe	293
Engerix-B Pediatric (PF).....	293
Envarsus XR	293
Epclusa oral pellets in packet 150-37.5 mg, 200-50 mg	65
Epclusa oral tablet 200-50 mg, 400-100 mg	65
Epidiolex	66
Eprontia.....	245
Erivedge	68
Erleada	69
erlotinib oral tablet 100 mg, 150 mg, 25 mg	70
ertapenem.....	12, 13
Erythrocine intravenous recon soln 500 mg	12, 13
Esbriet oral capsule	71

Esbriet oral tablet 267 mg, 801 mg	71
estradiol oral.....	98
estradiol transdermal patch semiweekly ...	98
estradiol transdermal patch weekly.....	98
estradiol-norethindrone acet.....	98
everolimus (antineoplastic) oral tablet 72, 73	
everolimus (antineoplastic) oral tablet for suspension	72, 73
everolimus (immunosuppressive)	293
Exkivity	74
Eysuvis	75
F	
Fasenra	76, 77
Fasenra Pen	76, 77
fentanyl citrate buccal lozenge on a handle	247
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	246
Ferriprox	56
Fintepla	78
Firdapse.....	79
Firmagon kit w diluent syringe	293
fluconazole in NaCl (iso-osm) intravenous piggyback 200 mg/100 mL, 400 mg/200 mL	14
formoterol fumarate	293
Fotivda	80
Fyavolv	98
G	
Gattex 30-Vial.....	81
Gavreto.....	82
Gengraf	293
gentamicin in NaCl (iso-osm) intravenous piggyback 100 mg/100 mL, 60 mg/50 mL, 80 mg/100 mL, 80 mg/50 mL .	12, 13
gentamicin injection solution 40 mg/mL .	12, 13
Gilenya oral capsule 0.5 mg.....	83
Gilotrif.....	84
glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL.....	85
Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL.....	85
Gralise oral tablet extended release 24 hr 300 mg, 600 mg	88

granisetron HCl oral.....	293
---------------------------	-----

H

Harvoni oral pellets in packet 33.75-150 mg, 45-200 mg	91
Harvoni oral tablet 90-400 mg.....	91
Hetlioz.....	92
Humira Pen	99, 100
Humira Pen Crohns-UC-HS Start.....	99, 100
Humira Pen Psor-Uveits-Adol HS	99, 100
Humira subcutaneous syringe kit 40 mg/0.8 mL	99, 100
Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL.....	99, 100
Humira(CF) Pen Crohns-UC-HS.....	99, 100
Humira(CF) Pen Pediatric UC	99, 100
Humira(CF) Pen Psor-Uv-Adol HS ..	99, 100
Humira(CF) Pen subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL..	99, 100
Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL	99, 100
hydromorphone oral tablet extended release 24 hr	126, 127
hydroxyzine HCl oral tablet.....	96

I

Ibrance.....	101
icatibant.....	102
Iclusig.....	103
Idhifa	104
imatinib oral tablet 100 mg, 400 mg.....	105
Imbruvica oral capsule 140 mg, 70 mg...	106
Imbruvica oral tablet 280 mg, 420 mg, 560 mg	106
imipenem-cilastatin.....	12, 13
Impavido	107
Inlyta oral tablet 1 mg, 5 mg.....	109
Inqovi	110
Inrebic	111
Intralipid intravenous emulsion 20 %	293
Intron A injection recon soln	293
ipratropium bromide inhalation	293
ipratropium-albuterol	293
Iressa	112

J

Jakafi	114
--------------	-----

Jinteli..... 98
 Juxtapid oral capsule 10 mg, 20 mg, 30 mg,
 5 mg 115, 116

K

Kalydeco oral granules in packet..... 117
 Kalydeco oral tablet 117
 Kisqali Femara Co-Pack oral tablet 200
 mg/day(200 mg x 1)-2.5 mg, 400
 mg/day(200 mg x 2)-2.5 mg, 600
 mg/day(200 mg x 3)-2.5 mg 118, 119
 Kisqali oral tablet 200 mg/day (200 mg x 1),
 400 mg/day (200 mg x 2), 600 mg/day
 (200 mg x 3)..... 118, 119
 Korlym 120
 Kynmobi sublingual film 10 mg, 15 mg, 20
 mg, 25 mg, 30 mg 121

L

lapatinib..... 122
 lenalidomide..... 199, 200
 Lenvima 123
 Leukine injection recon soln 124
 leuprolide subcutaneous kit..... 87
 levalbuterol HCl..... 293
 levofloxacin in D5W intravenous piggyback
 500 mg/100 mL, 750 mg/150 mL... 12, 13
 levofloxacin intravenous 12, 13
 lidocaine topical adhesive patch,medicated 5
 % 125
 linezolid in dextrose 5%..... 12, 13
 Lonsurf..... 128
 Lorazepam Intensol..... 93
 lorazepam oral tablet 0.5 mg, 1 mg, 2 mg 93
 Lorbrena oral tablet 100 mg, 25 mg..... 129
 Lumakras..... 131
 Lupron Depot 87
 Lupron Depot (3 month) 87
 Lupron Depot (4 month) 87
 Lupron Depot (6 Month)..... 87
 Lyllana 98
 Lynparza 132, 133

M

megestrol oral suspension 400 mg/10 mL
 (40 mg/mL), 625 mg/5 mL (125 mg/mL)
 134
 megestrol oral tablet..... 134
 Mekinist oral tablet 0.5 mg, 2 mg ... 135, 136

Mektovi 137
 memantine oral capsule,sprinkle,ER 24hr
 138
 memantine oral solution..... 138
 memantine oral tablet..... 138
 Menest oral tablet 0.3 mg, 0.625 mg, 1.25
 mg 98
 meropenem intravenous recon soln 1 gram,
 500 mg 12, 13
 methadone oral solution 10 mg/5 mL, 5
 mg/5 mL..... 126, 127
 methadone oral tablet 10 mg, 5 mg. 126, 127
 methotrexate sodium 293
 methotrexate sodium (PF) injection solution
 293
 methylprednisolone oral tablet..... 293
 metronidazole in NaCl (iso-os)..... 12, 13
 metyrosine..... 183
 miglustat..... 139
 Mimvey 98
 modafinil 140
 morphine oral tablet extended release.... 126,
 127
 Mounjaro..... 86
 moxifloxacin-sod.chloride(iso)..... 12, 13
 Mulpleta 141
 Myalept 142
 mycophenolate mofetil..... 293
 mycophenolate sodium 293

N

nafcillin injection 12, 13
 Namzaric 138
 Natpara..... 143
 Nayzilam 144
 Nerlynx 145
 Nexavar 146
 Nexletol..... 147, 148
 Nexlizet..... 149, 150
 nilutamide 151
 Ninlaro 152
 nitisinone..... 153
 Nivestym..... 154, 155
 norethindrone ac-eth estradiol oral tablet
 0.5-2.5 mg-mcg, 1-5 mg-mcg 98
 Noxafil oral suspension..... 188
 Nubeqa 159

Nucala subcutaneous auto-injector . 160, 161
 Nucala subcutaneous recon soln 160, 161
 Nucala subcutaneous syringe 100 mg/mL
 160, 161
 Nuedexta 162
 Nuplazid..... 163
 Nurtec ODT 164
 Nyvepria..... 165
O
 Ocaliva 166
 octreotide acetate injection solution..... 167
 Odomzo..... 168
 Ofev..... 169
 Omnitrope 89, 90
 ondansetron 293
 ondansetron HCl oral solution 293
 ondansetron HCl oral tablet 4 mg, 8 mg. 293
 Onureg..... 170
 Opsumit..... 171
 Orencia ClickJect..... 172
 Orencia subcutaneous syringe 125 mg/mL,
 50 mg/0.4 mL, 87.5 mg/0.7 mL 172
 Orgovyx 173
 Orkambi oral granules in packet 174
 Orkambi oral tablet 174
 Orladeyo..... 175
 Otezla 176
 Otezla Starter oral tablets,dose pack 10 mg
 (4)-20 mg (4)-30 mg (47)..... 176
 oxacillin in dextrose(iso-osm)..... 12, 13
 oxacillin injection..... 12, 13
 oxandrolone..... 11
 Oxervate..... 177
 OxyContin oral tablet,oral only,ext.rel.12 hr
 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60
 mg, 80 mg 126, 127
 Ozempic subcutaneous pen injector 0.25 mg
 or 0.5 mg(2 mg/1.5 mL), 1 mg/dose (4
 mg/3 mL), 2 mg/dose (8 mg/3 mL) 86
P
 Palynziq subcutaneous syringe 10 mg/0.5
 mL, 2.5 mg/0.5 mL, 20 mg/mL 178
 Panretin 179
 Pemazyre..... 180
 penicillamine oral tablet..... 181

penicillin G pot in dextrose intravenous
 piggyback 2 million unit/50 mL, 3 million
 unit/50 mL..... 12, 13
 penicillin G potassium injection recon soln
 20 million unit..... 12, 13
 penicillin G procaine intramuscular syringe
 1.2 million unit/2 mL 12, 13
 penicillin G sodium..... 12, 13
 pentamidine inhalation..... 293
 phenobarbital..... 97
 pimecrolimus..... 243
 Piqray 185
 pirfenidone oral tablet 267 mg, 801 mg.... 71
 Plegridy subcutaneous pen injector 125
 mcg/0.5 mL 186
 Plegridy subcutaneous syringe 125 mcg/0.5
 mL 186
 Plenamine..... 293
 Pomalyst..... 187
 posaconazole oral tablet,delayed release
 (DR/EC) 188
 Prehevbrio (PF) 293
 Premasol 10 % 293
 Privigen 113
 Procrit injection solution 10,000 unit/mL,
 2,000 unit/mL, 20,000 unit/mL, 3,000
 unit/mL, 4,000 unit/mL, 40,000 unit/mL
 67
 Prograf oral granules in packet 293
 Prolastin-C intravenous recon soln 9
 Prolia 189, 190
 Promacta 191, 192
 promethazine oral..... 96
 Pulmozyme 293
 pyrimethamine 193
Q
 Qinlock..... 194
R
 Ravicti 182
 Recombivax HB (PF) intramuscular
 suspension 10 mcg/mL, 40 mcg/mL... 293
 Recombivax HB (PF) intramuscular syringe
 293
 Repatha 195, 196
 Repatha Pushtronex 195, 196
 Repatha SureClick 195, 196

Retacrit.....	67	tacrolimus oral	293
Retevmo oral capsule 40 mg, 80 mg.....	197	tacrolimus topical.....	243
Revcovi	198	tadalafil (pulm. hypertension).....	184
Revlimid.....	199, 200	Tafinlar.....	226, 227
riluzole	201	Tagrisso.....	228
Rinvoq oral tablet extended release 24 hr 15 mg, 30 mg, 45 mg	202	Taltz Autoinjector	229
Rozlytrek oral capsule 100 mg, 200 mg .	203	Taltz Syringe.....	229
Rubraca	204	Talzenna oral capsule 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	230
rufinamide	205	Targretin topical.....	231
Rybelsus.....	86	Tasigna oral capsule 150 mg, 200 mg, 50 mg	232
Rydapt.....	206	tazarotene topical cream	233
S		Tazicef injection.....	12, 13
Sajazir	102	Tazorac topical cream 0.05 %.....	233
Samsca oral tablet 15 mg	242	Tazorac topical gel.....	233
Sandimmune oral solution	293	Tazverik	234
sapropterin.....	207	Teflaro.....	12, 13
Scemblix oral tablet 20 mg, 40 mg	208	Tepmetko	235
Signifor	210	teriparatide	236, 237
sildenafil (Pulmonary Arterial Hypertension) oral tablet.....	184	testosterone cypionate intramuscular oil 100 mg/mL, 200 mg/mL, 200 mg/mL (1 ML)	108
sirolimus.....	293	testosterone enanthate	108
Sirturo	211	testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)	156, 157
Skyrizi subcutaneous pen injector	212	testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)	156, 157
Skyrizi subcutaneous syringe 150 mg/mL	212	testosterone transdermal solution in metered pump w/app.....	156, 157
Skyrizi subcutaneous syringe kit	212	tetrabenazine oral tablet 12.5 mg, 25 mg	238
sodium phenylbutyrate.....	182	Thalomid.....	239, 240
Somavert	214	Tibsovo	241
Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	215	tigecycline	12, 13
Stelara subcutaneous solution.....	216, 217	tobramycin in 0.225 % NaCl	293
Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL.....	216, 217	tobramycin inhalation	293
Stivarga	218	tobramycin sulfate injection solution..	12, 13
streptomycin.....	12, 13	tolvaptan.....	242
Sucraid	219	topiramate oral capsule, sprinkle	245
sunitinib.....	220	topiramate oral tablet	245
Symdeko	221	Travasol 10 %	293
SymlinPen 120.....	222	Trelstar intramuscular suspension for reconstitution.....	293
SymlinPen 60.....	222		
Sympazan.....	45		
Synarel	223		
Synribo.....	293		
T			
Tabrecta.....	224		

tretinoin topical	244
trientine	248
Trikafta.....	249
TrophAmine 10 %.....	293
Trulicity.....	86
Truseltiq oral capsule 100 mg/day (100 mg x 1), 125 mg/day(100 mg x1-25mg x1), 50 mg/day (25 mg x 2), 75 mg/day (25 mg x 3)	250
Tukysa oral tablet 150 mg, 50 mg	251
Turalio.....	252
U	
Ubrelvy	253
Uptravi oral	254
V	
Valchlor.....	255
Valtoco.....	256
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg.....	12, 13
vancomycin oral capsule 125 mg, 250 mg	257
Varubi	293
Venclexta oral tablet 10 mg, 100 mg, 50 mg	258
Venclexta Starting Pack.....	258
Verzenio.....	259, 260
Victoza 3-Pak.....	86
Vitrakvi oral capsule 100 mg, 25 mg.....	261
Vitrakvi oral solution	261
Vizimpro	262
Vonjo.....	263
voriconazole.....	14, 264
Vosevi	265
Votrient	266
Vumerity	267
Vyndamax	225
Vyndaqel.....	225
W	
Welireg.....	268

X	
Xalkori	269
Xatmep.....	293
Xeljanz oral solution	270, 271
Xeljanz oral tablet.....	270, 271
Xeljanz XR.....	270, 271
Xermelo.....	272
Xgeva	293
Xolair subcutaneous recon soln	273, 274
Xolair subcutaneous syringe 150 mg/mL, 75 mg/0.5 mL.....	273, 274
Xospata	275
Xpovio oral tablet 100 mg/week (50 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 80mg twice week (160 mg/week)	276, 277
Xtandi oral capsule	278
Xtandi oral tablet 40 mg, 80 mg	278
Xuriden	279
Xyrem	280
Y	
Yonsa	281
Z	
Zarxio.....	282, 283
Zejula	284
Zelboraf.....	285
Zeposia.....	286
Zeposia Starter Kit	286
Zeposia Starter Pack	286
Ziextenzo.....	287
Zolinza	288
zonisamide	245
Zortress oral tablet 1 mg	293
Zydelig	289
Zykadia oral tablet	290