2024

Tufts Health One Care
(Medicare-Medicaid Plan)

2024 Prior Authorization Medical Necessity Guidelines

Effective: **03/01/2024**

The Formulary may change at any time. You will receive notice when necessary.

TUFTS Health Plan

a **Point32Health** company

091223

ABILIFY MYCITE

Products Affected

- Abilify Mycite
- Abilify Mycite Maintenance Kit
- Abilify Mycite Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following: 1) have a documented diagnosis of bipolar I disorder, major depressive disorder or schizophrenia 2) the member must have documentation of worsening symptoms with oral aripiprazole.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a psychiatrist.
Coverage Duration	2 years
Other Criteria	None

ABIRATERONE

Products Affected

- Abiraterone Acetate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic castration-resistant prostate cancer (CRPC) or metastatic high-risk castration-sensitive prostate cancer and abiraterone is being used in combination with prednisone.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Initial: The member must have a documented diagnosis of migraine and the member has had an inadequate response after a 4-week trial of or has a contraindication to antidepressants, antiepileptic drugs (AEDs) or beta blockers. Subsequent: The member has had a clinically significant reduction in migraine days per month from baseline.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 6 months. Subsequent approval: 2 years
Other Criteria	None

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Anaplastic Lymphoma Kinase positive (ALK-positive), metastatic Non-small Cell Lung Cancer (NSCLC).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Cryopyrin-associated periodic syndromes: The member must have a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome, including Familial Cold Autoinflammatory Syndrome, or Muckle-Wells Syndrome. Deficiency of interleukin-1 receptor antagonist: The member must have a documented diagnosis of deficiency of interleukin-1 receptor antagonist and Arcalyst is being used for maintenance of remission in patients weighing 10kg or more. Recurrent Pericarditis (RP): The member must have a documented diagnosis of RP and Arcalyst is being used to reduce the risk of recurrence.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Mycobacterium Avium Complex (MAC) lung disease and meets the following: 1) has limited or no alternative treatment options and 2) does not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ARMODAFINIL AND MODAFINIL

Products Affected

- Armodafinil
- Modafinil TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be approved for generalized fatigue, jet lag, or sleep-deprivation not associated with a covered diagnosis.
Required Medical Information	The member must have a documented diagnosis of narcolepsy, excessive sleepiness associated with obstructive sleep apnea, or shift-work sleep disorder.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be approved for the treatment of iron deficiency anemia in patients with CKD not on dialysis.
Required Medical Information	The member must have a documented diagnosis of hyperphosphatemia associated with chronic kidney disease (CKD) and receiving dialysis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chorea Associated with Huntington's Disease: The member must have a documented diagnosis of chorea associated with Huntington's Disease. Tardive Dyskinesia: The member must have a documented diagnosis of Tardive Dyskinesia.
Age Restrictions	None
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	None

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Systemic Mastocytosis (AdvSM): The member must have a documented diagnosis of AdvSM, which includes aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL). Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of PDGFRA Exon 18 mutation-positive, including PDGFRA D842V mutations, unresectable or metastatic GIST.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist, immunologist, or oncologist.
Coverage Duration	2 years
Other Criteria	None

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of locally advanced or metastatic urothelial carcinoma that has susceptible FGFR3 or FGFR2 genetic alterations and the member progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

BENLYSTA

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Benlysta (belimumab) will not be approved as monotherapy, for members with severe active lupus nephritis or severe active central nervous system lupus, for members who are autoantibody negative, or in combination with other biologics or intravenous cyclophosphamide.
Required Medical Information	The member must have a documented diagnosis of active, autoantibody-positive (e.g., ANA, anti-ds-DNA, anti-Sm) systemic lupus erythematosus (SLE) or active lupus nephritis and is concurrently taking standard therapy (e.g., antimalarials, corticosteroids, or immunosuppressives).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a nephrologist or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist or immunologist.
Coverage Duration	2 years
Other Criteria	None

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of polycythemia vera.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

BEXAROTENE GEL

Products Affected

- Bexarotene GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of cutaneous T-cell lymphoma with refractory or persistent disease after other therapies or with an intolerance to other therapies.
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be an oncologist or dermatologist.
Coverage Duration	2 years
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with a documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec) or the member is newly diagnosed with chronic phase Ph+ CML.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

BRAFTOVI

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF CRC.
Required Medical Information	Metastatic Colorectal Cancer (CRC): The member must have a documented diagnosis of metastatic CRC with a BRAF V600E mutation after prior therapy and will be taken in combination with cetuximab. Melanoma (unresectable or metastatic): The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation and will be taken in combination with Mektovi (binimetinib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) Mantle Cell Lymphoma (MCL) and has received at least one prior therapy or 2) Relapsed or refractory Marginal Zone Lymphoma (MZL) and has received at least one anti-CD20-based regimen, 3) Waldenstrom's Macroglobulinemia, 4) chronic lymphocytic leukemia (CLL), or 5) small lymphocytic lymphoma (SLL).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

BYLVAY

Products Affected

- Bylvay
- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Bylvay will not be approved for members with PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3).
Required Medical Information	The member must have a documented diagnosis of pruritus with progressive familial intrahepatic cholestasis (PFIC) or Alagille syndrome.
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a hepatologist, gastroenterologist, or a provider who specializes in progressive familial intrahepatic cholestasis.
Coverage Duration	2 years
Other Criteria	None

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of advanced renal cell carcinoma (RCC). Differentiated Thyroid Cancer (DTC): The member must have a documented diagnosis of locally advanced or metastatic DTC that has progressed following prior VEGFR-targeted therapy and are radioactive iodine-refractory or ineligible. Hepatocellular Carcinoma (HCC): The member must have a documented diagnosis of HCC and has had a documented failure, contraindication, or intolerance with Nexavar (sorafenib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of CLL or SLL. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and has received at least one prior therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

CAMZYOS

Products Affected

- Camzyos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM).
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be a cardiologist.
Coverage Duration	2 years
Other Criteria	N/A

CAPLYTA

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of schizophrenia or bipolar depression.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a psychiatrist.
Coverage Duration	2 years
Other Criteria	None

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

CARGLUMIC

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have one of the following: 1) a documented diagnosis of hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency. 2) a documented diagnosis of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) and the requested drug is being used as adjunctive therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis with Pseudomonas aeruginosa.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Gaucher Disease type 1 and documentation the member is a cytochrome P450 2D6 extensive metabolizer (EMs), intermediate metabolizer (IMs), or poor metabolizer (PMs).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Cholbam will not be approved for members with extrahepatic manifestations of either bile acid synthesis disorders due to single enzyme defects (SEDs) or peroxisomal disorders (PDs), including Zellweger spectrum disorders.
Required Medical Information	Bile Acid Synthesis Disorder: The member must have a documented diagnosis of bile acid synthesis disorders due to single enzyme defects (SEDs). Peroxisomal Disorders (PDs): The member must have a documented diagnosis of PDs, including Zellweger spectrum disorders, and exhibit manifestations of hepatic disease, steatorrhea, or complications from decreased fat soluble vitamin absorption and Cholbam is being used as adjunctive therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist or immunologist.
Coverage Duration	2 years
Other Criteria	None

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of progressive, metastatic medullary thyroid cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of relapsed or refractory CLL or SLL and has received at least two prior therapies.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

COSENTYX

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Non-radiographic Axial Spondyloarthritis: The member must have a documented diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) and has had a minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., ibuprofen, meloxicam, naproxen) at maximally indicated doses. Enthesitis-related Arthritis (ERA): The member must have a documented diagnosis of active ERA and has had a minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., ibuprofen, meloxicam, naproxen). Hidradenitis Suppurativa: The member must have a documented diagnosis of moderate-to-severe hidradenitis suppurativa.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	2 years

Other Criteria	None

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Cotellic is not indicated for treatment of patients with wild-type BRAF melanoma.
Required Medical Information	The member must have a documented diagnosis of 1) unresectable or metastatic melanoma with a BRAF V600E or V600K mutation and is being taken in combination with Zelboraf (vemurafenib) or 2) histiocytic neoplasm and is being used as monotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acute myelogenous leukemia (AML) and Daurismo is being used as first-line therapy in combination with low-dose cytarabine and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

DESOXYN/METHAMPHETAMINE ORAL TABLET

Products Affected

- Methamphetamine Hcl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Desoxyn and methamphetamine oral tablets are not covered for narcolepsy and are excluded from coverage for exogenous obesity.
Required Medical Information	The member must have a documented diagnosis of ADHD.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of seizures associated with Dravet syndrome and is concurrently taking clobazam.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

DICHLORPHENAMIDE

Products Affected

- Dichlorphenamide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

DICLOFENAC EPOLAMINE PATCH

Products Affected

- Diclofenac Epolamine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acute pain due to one of the following: minor strain, sprain, or contusion.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

DOPTELET

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of one of the following: 1) Thrombocytopenia associated with chronic liver disease (CLD) and is scheduled to undergo a procedure 2) Thrombocytopenia with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

DROXIDOPA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of neurogenic orthostatic hypotension (NOH).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Dupixent will not be approved for the relief of acute bronchospasm or status asthmaticus.
Required Medical Information	Atopic Dermatitis: The member must have a documented diagnosis of moderate to severe atopic dermatitis with a trial and failure of a minimum 30-day supply (or 14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus ointment, or Eucrisa (crisaborole) ointment. Asthma: The member must have a documented diagnosis of moderate-to- severe asthma with an eosinophilic phenotype or is dependent on oral corticosteroids. Rhinosinusitis (chronic) with nasal polyposis: The member must have a documented diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) and is inadequately controlled on current treatment alone. Prurigo Nodularis: The member must have a document diagnosis of Prurigo Nodularis.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an allergist, dermatologist, immunologist, otolaryngologist, pulmonologist, or gastroenterologist.
Coverage Duration	2 years
Other Criteria	None

EGRIFTA

Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of HIV-associated lipodystrophy with excess abdominal fat.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Initial Approval: The member must have a documented diagnosis of one of the following: 1) Migraine and the member has had an inadequate response, contraindication, or inability to tolerate an appropriate trial after 4-weeks with at least one drug from the following classes: antidepressants (including but not limited to: amitriptyline, venlafaxine), antiepileptic drugs (including but not limited to: divalproex sodium, topiramate) or beta blockers (including but not limited to: propranolol, timolol) 2) Episodic Cluster headache. Subsequent Approval: The member has had a clinically significant reduction in migraine days per month or the frequency of weekly cluster headache attacks from baseline.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 6 months. Subsequent Approval: Life of Plan.
Other Criteria	None

ENBREL

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	None

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or tuberous sclerosis complex (TSC).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic basal cell carcinoma or locally advanced basal cell carcinoma that has recurred following surgery, or the member is not a candidate for surgery or radiation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of one of the following: 1) non-metastatic, castration-resistant prostate cancer 2) metastatic, castration-sensitive prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

ESBRIET

Products Affected

- Esbriet
- Pirfenidone CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a pulmonologist.
Coverage Duration	2 years
Other Criteria	None

EUCRISA

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Members 2 years to 17 years of age: The member must have a documented diagnosis of mild-to-moderate atopic dermatitis and an inadequate treatment response, intolerance, or contraindication to BOTH a low potency topical corticosteroid and a topical calcineurin inhibitor (including but not limited to: tacrolimus, pimecrolimus). Members 18 years of age or older: The member must have a documented diagnosis of mild-to-moderate atopic dermatitis and an inadequate treatment response, intolerance, or contraindication to BOTH a high potency topical corticosteroid and a topical calcineurin inhibitor (including but not limited to: tacrolimus, pimecrolimus).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or pediatrician.
Coverage Duration	2 years
Other Criteria	None

EVENITY

Products Affected

- Evenity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must be a postmenopausal woman with a documented diagnosis of osteoporosis with high risk of fracture, defined as a history of osteoporotic fracture or multiple risk factors for fracture, and the member has had an inadequate response to or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments [including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)].
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Lifetime coverage duration of Evenity should be limited to 12 monthly doses.
Other Criteria	None

EVEROLIMUS

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC): The member must have a documented diagnosis of Advanced HR+ BC, the member is postmenopausal, concurrently taking exemestane (Aromasin) and has a documented failure of letrozole (Femara) or anastrozole (Arimidex). Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC and the member has a demonstrated disease progression or intolerance following a trial with Nexavar (sorafenib) or Sutent (sunitinib). Neuroendocrine Tumors (NET): The member must have a documented diagnosis of progressive neuroendocrine tumors of pancreatic origin (pNET) or progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin, any of which are unresectable, locally advanced or metastatic. Renal Angiomyolipoma with Tuberous Sclerosis Complex (TSC): The member must have a documented presence of TSC and renal angiomyolipoma(s) greater than or equal to 3 cm in longest diameter. Subependymal Giant Cell Astrocytoma (SEGA): The member must have a documented diagnosis of SEGA associated with TSC and the member is not a candidate for surgical resection.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

EVEROLIMUS FOR ORAL SUSPENSION

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Partial-onset Seizures Associated with Tuberous Sclerosis Complex (TSC): The member must have a documented diagnosis of partial-onset seizures associated with TSC and is using the requested drug as an adjunct to other therapies (e.g., anticonvulsants). Subependymal Giant Cell Astrocytoma (SEGA): The member must have a documented diagnosis of SEGA associated with TSC and the member is not a candidate for surgical resection.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

EVRYSDI

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of spinal muscular atrophy (SMA).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations and has progressed on or after platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of severe asthma with an eosinophilic phenotype despite current treatment with both of the following medications: 1) inhaled corticosteroids 2) additional controller (Long-Acting Beta2-Agonist, Leukotriene Modifier, or Sustained Release Theophylline).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an asthma specialist (e.g., allergist, immunologist, pulmonologist).
Coverage Duration	2 years
Other Criteria	None

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Lambert-Eaton myasthenic syndrome (LEMS).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML
- Teriparatide INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The requesting physician must provide documentation that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments (including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast)).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years unless the member remains at or has returned to having high risk for fracture
Other Criteria	None

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory advanced renal cell carcinoma following two or more prior systemic therapies.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

FRUZAQLA

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy, and B) Anti-VEGF biological therapy (e.g., bevacizumab, ramucirumab). One of the following: A) Patient does not have RAS wild type tumors, OR B) Both of the following: a) Patient has RAS wild type tumors, AND b) Trial and failure, contraindication, or intolerance to an anti-EGFR biological therapy (e.g., panitumumab, cetuximab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist, nephrologist, or a specialist in metabolic diseases or genetics.
Coverage Duration	2 years
Other Criteria	None

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Short Bowel Syndrome (SBS) and is dependent on parenteral nutrition.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic rearranged during transfection (RET) fusion-positive NSCLC. Thyroid Cancer: The member must have both 1) a documented diagnosis of advanced or metastatic medullary thyroid cancer or advanced or metastatic thyroid cancer 2) documentation of RET-mutant or RET fusion-positive cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of one of the following: 1) Metastatic non-small cell lung cancer (NSCLC) and documented non-resistant epidermal growth factor receptor (EGFR) mutations 2) Metastatic, squamous cell NSCLC and documentation that the disease has progressed following platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

GLP1

Products Affected

- Bydureon Bcise
- Byetta
- Mounjaro
- Ozempic
- Rybelsus
- Trulicity
- Victoza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Type 2 Diabetes (initial): 1) Documented diagnosis of Type 2 Diabetes OR 2) Trial and failure of a minimum 90-day supply, contraindication, or intolerance to one product from any of the following drugs/classes: metformin-containing agent, DPP-4 inhibitors, DPP-4 inhibitor combinations, SGLT2 inhibitors, SGLT2 inhibitor combinations, alpha-glucosidase inhibitors, meglitinide analogues, suflonylurea, or sulfonylurea combinations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	Type 2 diabetes mellitus (Reauthorization): Patient demonstrates positive clinical response to therapy

GOCOVRI

Products Affected

- Gocovri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Parkinson's Disease and an inadequate response, intolerance, or contraindication to amantadine immediate release.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

GROWTH HORMONE REPLACEMENT THERAPY

Products Affected

- Genotropin
- Genotropin Miniquick
- Norditropin Flexpro
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Omnitrope
- Serostim INJ 4MG, 5MG, 6MG
- Zorbtive

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Pediatric GHD, Initiation: Member has not attained epiphyseal closure as determined by X-ray, have failed to respond to at least TWO standard GH stimulation test, have documented gender-specific delayed bone age, have the height at initiation of therapy at greater than 2 standard deviations below normal mean for age and sex. Member must have one of the following: Chronic Renal Insufficiency prior to transplantation, Idiopathic Short Stature, Intrauterine Growth Retardation, Non-genetic GHD, Noonan Syndrome, Prader-Willi Syndrome, Short Stature Homeobox-containing gene (SHOX) deficiency, or Turner Syndrome. Pediatric GHD, Continuation: Documentation of the following is required: Medical history as it relates to growth, including any test results and growth chart, continuing care plan and an improvement in the annualized pre-treatment growth rate after the first six (6) months of therapy. Continuation of Therapy after Completion of Linear Growth: Member will be re-evaluated after GH treatments have been stopped for at least three (3) months to determine growth hormone status AND member must have failed to respond to at least one standard GH stimulation test. Acquired GHD: Member must have failed to respond to at least one standard GH stimulation test. AIDS Wasting Syndrome: Documented diagnosis of AIDS AND a weight loss of at least 10% from baseline weight OR a BMI of less than 20. Short Bowel Syndrome: Documented diagnosis of Short Bowel Syndrome from a gastroenterologist AND a documented dependence on IPN for nutritional support.
Age Restrictions	None
Prescriber Restrictions	None

Coverage Duration	2 years
Other Criteria	None

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist or immunologist.
Coverage Duration	2 years
Other Criteria	None

HARVONI

Products Affected

- Harvoni PACK
- Harvoni TABS 90MG; 400MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	None

HETLIOZ

Products Affected

- Hetlioz Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be authorized for the diagnosis of insomnia.
Required Medical Information	Hetlioz Suspension: The member must have a documented diagnosis of Smith-Magenis Syndrome (SMS) and be experiencing nighttime sleep disturbances.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist or sleep specialist.
Coverage Duration	2 years
Other Criteria	None

HUMIRA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None

Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease (CD): The member must have a documented diagnosis CD and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisone, or methotrexate. Ulcerative Colitis (UC): The member must have a documented diagnosis UC and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisone). Hidradenitis Suppurativa: The member must have a documented diagnosis of moderate-to-severe hidradenitis suppurativa. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine. Uveitis: The member must have a documented diagnosis of non-infectious uveitis.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, gastroenterologist, ophthalmologist, or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

HYFTOR

Products Affected

- Hyftor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must meet the following: Have a documented diagnosis of tuberous sclerosis complex (TSC) with 3 or more papules of angiofibroma (greater than or equal to 2 mm in diameter with redness in each) on the face at screening tests.
Age Restrictions	N/A
Prescriber Restrictions	The drug must be prescribed by, or in consultation with, a dermatologist, neurologist or geneticist.
Coverage Duration	1 year
Other Criteria	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must 1) have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and Ibrance is being used in combination with an aromatase inhibitor or 2) have a documented diagnosis of HR-positive, HER2- negative advanced or metastatic breast cancer with disease progression following endocrine therapy and documentation Ibrance (palbociclib) will be used in combination with Faslodex (fulvestrant).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ICATIBANT

Products Affected

- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Icatibant will not be approved for members with acquired angioedema or concurrently taking an angiotensin converting enzyme (ACE) inhibitor.
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema (HAE) with a history of at least one severe attack in the past six months. For HAE Types 1 & 2, the diagnosis must be confirmed by laboratory testing (e.g., low C4 level, reduced C1 esterase inhibitor level or function).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist, hematologist, or immunologist.
Coverage Duration	2 years
Other Criteria	None

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Iclusig will not be approved for members with newly diagnosed chronic phase CML.
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member must be T315I-positive or have a documented diagnosis of Philadelphia chromosome-positive ALL (Ph+ALL) for which no other tyrosine kinase inhibitor therapy is indicated. Chronic Myeloid Leukemia (CML): The member must be T315I-positive or have a documented diagnosis of chronic phase, accelerated phase, or blast phase CML for which no other tyrosine kinase inhibitor therapy is indicated. The member must have a diagnosis of Chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least two prior kinase inhibitors.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD AND trial and failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist, oncologist, or transplant specialist.
Coverage Duration	2 years
Other Criteria	None

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage of Increlex will not be authorized for conditions resulting in secondary forms of IGF-1 deficiency that include, but are not limited to: GH deficiency, malnutrition, hypothyroidism, or chronic steroid therapy.
Required Medical Information	The member must have a documented diagnosis of severe primary IGF-1 deficiency as defined by a height SD score less than or equal to -3.0, a basal IGF-1 SD score less than or equal to -3.0 , normal or elevated GH level OR GH gene deletion and has developed neutralizing antibodies to GH. Radiographs documenting open epiphyses are required for members who are Tanner stage III or greater.
Age Restrictions	The member must be 2 to 18 years of age.
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	Initial authorization is for 6 months. Subsequent authorizations are for 1 year.
Other Criteria	None

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of tardive dyskinesia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced renal cell carcinoma and one of the following two requirements: 1) The member is using Inlyta as first line treatment in combination with avelumab or pembrolizumab 2) The member is using Inlyta as a single agent and has failed a trial of at least one systemic therapy (including but not limited to everolimus, Nexavar, sunitinib, Torisel, Votrient).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

IRESSA

Products Affected

- Gefitinib
- Iressa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) in tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Graft-versus-host Disease (GVHD): The member must have a documented diagnosis of chronic GVHD after failure of one or two lines of systemic therapy. Myelofibrosis: The member must have a documented diagnosis of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. Polycythemia Vera: The member must have a documented diagnosis of polycythemia vera with an inadequate response, contraindication, or inability to tolerate hydroxyurea. Steroid-Refractory Acute Graft-versus-host Disease (GVHD): The member must have a document diagnosis of steroid-refractory acute GVHD.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 Years
Other Criteria	For Myelofibrosis: Subsequent authorization requires documentation of spleen size reduction or symptomatic improvement.

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory mantle cell lymphoma (MCL). Documentation the member has received at least two prior lines of systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A

JUXTAPID

Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must 1) have a documented diagnosis of homozygous familial hypercholesterolemia (HoFH) based on one of the following tests: a) LDLR DNA Sequence Analysis. b) LDLR Deletion/Duplication Analysis for large gene rearrangement testing (only if the Sequence Analysis is negative). c) APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists and 2) be concurrently taking lipid-lowering medications or has a documented contraindication to lipid-lowering medications and has had a documented inadequate response, intolerance, or a contraindication to a PCSK9 Inhibitor.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Kalydeco is not effective in patients with cystic fibrosis who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) and have one mutation in the CFTR gene that is responsive to Kalydeco based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.
Age Restrictions	Granules: The member must be 1 month of age or older.
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

KERENDIA

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chronic kidney disease associated with type 2 diabetes.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

KESIMPTA

Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA and either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), Humira (adalimumab), Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib). Neonatal-Onset Multisystem Inflammatory Disease (NOMID): Diagnosis of NOMID
Age Restrictions	N/A
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist. NOMID: Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.
Coverage Duration	2 years
Other Criteria	N/A

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with 1) an aromatase inhibitor as initial endocrine-based therapy or 2) fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in postmenopausal women or in men.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

KLISYRI

Products Affected

- Klisyri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of actinic keratosis of the face or scalp.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperglycemia secondary to hypercortisolism with endogenous Cushing's syndrome and type 2 diabetes mellitus OR glucose intolerance AND has failed surgery OR is not a candidate for surgery.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Neurofibromatosis type 1 and have symptomatic, inoperable plexiform neurofibromas.
Age Restrictions	The member must be 2 to 17 years of age.
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is 1) locally advanced or metastatic 2) KRAS G12C-mutated and 3) patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A

LAPATINIB

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	For estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2) overexpressing advanced or metastatic breast cancer, the member must meet ALL of the following criteria: 1) Documented diagnosis of HER2 overexpressing advanced or metastatic breast cancer. 2) The member has failed prior therapy with an anthracycline and a taxane chemotherapeutic agent. 3) The member has failed prior therapy with Herceptin (trastuzumab). 4) The member is concurrently treated with capecitabine (Xeloda). Hormone Receptor Positive Metastatic Breast Cancer in Post-menopausal Women: The member must have a documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor and is concurrently being treated with an aromatase inhibitor (including but not limited to: anastrozole, exemestane, or letrozole).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LENALIDOMIDE

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Follicular Lymphoma (FL): The member must have a documented diagnosis of previously treated FL and the requested drug is being used in combination with a rituximab product. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and the member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib). Marginal Zone Lymphoma (MZL): The member must have a documented diagnosis of previously treated MZL and the requested drug is being used in combination with a rituximab product. Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and requested drug is being used in combination with dexamethasone or as maintenance therapy in a member following autologous hematopoietic stem cell transplantation. Myelodysplastic Syndrome (MDS): The member must have a documented diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with the 5q-deletion cytogenetic abnormality.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Endometrial Carcinoma: The member must have a documented diagnosis of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation and it will be used in combination with Keytruda (pembrolizumab). Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC and 1) has had one prior antiangiogenic therapy and is being used in combination with Afinitor (everolimus) or 2) being used as first-line treatment in combination with pembrolizumab. Hepatocellular carcinoma (HCC): The member must have a documented diagnosis of unresectable hepatocellular carcinoma. Thyroid Cancer: The member must have a documented diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LIDOCAINE TRANSDERMAL PATCHES

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	For Postherpetic Neuralgia or Diabetic Neuropathy, the member must have had a failure, adverse reaction, or contraindication to gabapentin. Lidocaine transdermal patches will also be approved for members who are not candidates for opioid or other oral pain management therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	Coverage will be authorized for new members if their pain is currently well-controlled on lidocaine transdermal patches.

LIVMARLI

Products Affected

- Livmarli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cholestatic pruritus due to Alagille syndrome (ALGS).
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a gastroenterologist, hepatologist or a provider that specializes in Alagille syndrome (ALGS).
Coverage Duration	2 years
Other Criteria	None

LIVTENCITY

Products Affected

- Livtencity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member, weighing 35kg or more, must have a documented diagnosis of post-transplant cytomegalovirus (CMV) infection/disease, that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Metastatic Colorectal Cancer (mCRC): The member must have a documented diagnosis of mCRC and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) biological therapy, and if rat sarcoma viral oncogene (RAS) wild-type, an anti-epidermal growth factor receptor (EGFR) therapy. Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma: The member must have a documented diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma and has been previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) and has received at least one prior systemic therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of schizophrenia or Bipolar I disorder.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a psychiatrist.
Coverage Duration	2 years
Other Criteria	None

LYNPARZA

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Breast Cancer: Diagnosis of deleterious gBRCA-mutated, HER2-negative 1) metastatic breast cancer and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting and, if hormone receptor-positive, the member should have prior endocrine therapy or contraindication to or inability to tolerate endocrine therapy or 2) high risk early breast cancer, has been treated with neoadjuvant or adjuvant chemotherapy. Ovarian Cancer: 1) Maintenance treatment of deleterious or suspected deleterious germline or somatic BRCA-mutated advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to first-line platinum-based chemotherapy 2) Maintenance treatment of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in combination with bevacizumab and the member is in complete or partial response to first-line platinum-based chemotherapy and the members cancer is associated with homologous recombination deficiency (HRD)-positive status 3) Maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and the member is in complete or partial response to platinum-based chemotherapy. Pancreatic Cancer: The member has a diagnosis of deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma and no disease progression after at least 16 weeks of first-line platinum-based chemotherapy. Prostate Cancer: The member has a documented diagnosis of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC) who have progressed following prior treatment with enzalutamide or abiraterone or a documented diagnosis of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) and is being used in combination with abiraterone and prednisone or prednisolone.
Age Restrictions	None

Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

LYTGOBI

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of previously treated, unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	None

MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

Products Affected

- Adempas
- Alyq
- Ambrisentan
- Bosentan
- Opsumit
- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG
- Tracleer TBSO
- Uptravi TABS
- Uptravi Titration Pack
- Ventavis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Pulmonary arterial hypertension (PAH) The member must have a documented diagnosis of pulmonary arterial hypertension as confirmed by right heart catheterization. Chronic thromboembolic pulmonary hypertension (CTEPH) Diagnosis of persistent/recurrent CTEPH (after surgical treatment or inoperable)
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist or pulmonologist.
Coverage Duration	2 years
Other Criteria	None

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Mekinist will not be approved as a single agent for members who have received prior BRAF-inhibitor therapy.
Required Medical Information	Single Agent: The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutations. In Combination with Tafinlar: The member must have a documented diagnosis of one of the following: 1) Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. 2) Melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection. 3) Metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation. 4) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with a BRAF V600E mutation with no satisfactory locoregional treatment options. 5) Unresectable or metastatic solid tumors with BRAF V600E mutation and has progressed following prior treatment. 6) low grade glioma with BRAF V600E mutation that requires systemic therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, and will be taken in combination with Braftovi (encorafenib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

MIGLUSTAT

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of mild-to-moderate Gaucher disease type 1 and enzyme replacement therapy is not a therapeutic option (e.g. allergy, hypersensitivity, poor venous access).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

MISCELLANEOUS INJECTABLES

Products Affected

- Abelcet
- Acyclovir Sodium INJ 50MG/ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Cortrophin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Diagnosis of an FDA-approved indication not otherwise excluded from Part D.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

MYFEMBREE

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must be premenopausal and have meet one of the following criteria: 1) a documented diagnosis of uterine leiomyomas (fibroids) associated with heavy menstrual bleeding or 2) a documented diagnosis of moderate to severe pain associated with endometriosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Coverage of Myfembree is limited to 24 months.
Other Criteria	None

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Natpara will not be approved for members who are well-controlled on calcium supplements and active forms of vitamin D alone, or for members with hypoparathyroidism caused by calcium-sensing receptor mutations or acute postsurgical hypoparathyroidism.
Required Medical Information	The member must have a documented diagnosis of hypocalcemia secondary to hypoparathyroidism. Before starting Natpara, the prescriber must confirm sufficient 25-hydroxyvitamin D stores and that serum calcium is above 7.5 mg/dL.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	2 years
Other Criteria	None

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of a seizure disorder requiring acute treatment.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Extended Adjuvant Treatment of Early-stage Breast Cancer: The member must have a documented diagnosis of early stage human epidermal growth receptor type 2 (HER2)-positive breast cancer and has had previous adjuvant treatment with Herceptin-based therapy. Advanced or Metastatic Breast Cancer: The member must have a documented diagnosis of advanced or metastatic HER2-positive breast cancer, is using Nerlynx in combination with capecitabine, and has received two or more prior anti-HER2 based regimens.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

NEXLETOL

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with maximally tolerated statin therapy or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Heterozygous Familial Hypercholesterolemia (HeFH) b) atherosclerotic cardiovascular disease
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a cardiologist, endocrinologist, lipidologist, or neurologist.
Coverage Duration	2 years
Other Criteria	None

NEXLIZET

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with maximally tolerated statin therapy or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Heterozygous Familial Hypercholesterolemia (HeFH) b) atherosclerotic cardiovascular disease.
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a cardiologist, endocrinologist, lipidologist, or neurologist.
Coverage Duration	2 years
Other Criteria	None

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of multiple myeloma and Ninlaro is being used in combination with Revlimid (lenalidomide) and dexamethasone in patients who have received at least one prior therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

NITISINONE

Products Affected

- Nitisinone CAPS 10MG, 2MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hereditary tyrosinemia type-1 (HT-1).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of non-metastatic castration-resistant prostate cancer or metastatic hormone-sensitive prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member must have a documented diagnosis of severe asthma with an eosinophilic phenotype and documentation that underlying conditions or triggers for asthma or pulmonary disease are being maximally managed. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP): The member must have a documented diagnosis of CRSwNP and has had an inadequate response to nasal corticosteroids. Eosinophilic granulomatosis with polyangiitis: The member must have a documented diagnosis of eosinophilic granulomatosis with polyangiitis and has had an inadequate response to an appropriate trial with at least one of the following immunosuppressants: azathioprine, cyclophosphamide, or methotrexate. Hypereosinophilic Syndrome (HES): The member must have a documented diagnosis of HES for at least 6 months without an identifiable non-hematologic secondary cause.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an asthma specialist (e.g., allergist, immunologist, pulmonologist), hematologist, otolaryngologist, or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of pseudobulbar affect (PBA).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Parkinson's disease and have hallucinations and delusions associated with Parkinson's disease psychosis.
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	2 years
Other Criteria	None

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) acute migraine and has had an inadequate response, intolerance, or contraindication to at least one triptan medication OR 2) episodic migraine.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of locally advanced basal cell carcinoma and one of the following: 1) Documentation of disease recurrence following surgery or radiation therapy or 2) Documentation that the member is not a candidate for surgery or radiation therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of one of the following: 1) idiopathic pulmonary fibrosis (IPF) 2) systemic sclerosis-associated interstitial lung disease (SSc-ILD) or 3) chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a pulmonologist.
Coverage Duration	2 years
Other Criteria	None

OJJAARA

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [post-polycythemia vera (PV) and post-essential thrombocythemia (ET)], in adults with anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acute myeloid leukemia and has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

ORENCIA

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML
- Orencia Clickject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA): The member must have a documented diagnosis RA and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of PJIA and has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine Psoriatic Arthritis (PsA): The member must have a documented diagnosis of psoriatic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, rheumatologist, oncologist, or transplant specialist.
Coverage Duration	2 years
Other Criteria	N/A

ORFADIN

Products Affected

- Nitisinone CAPS 20MG
- Orfadin CAPS 20MG
- Orfadin SUSP

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hereditary tyrosinemia type-1 (HT-1).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

ORILISSA

Products Affected

- Orilissa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of endometriosis with moderate-to-severe pain.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) and have documentation that the member is homozygous for the F508del mutation on both alleles of the CFTR gene.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

ORSERDU

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have documented diagnosis of advanced or metastatic breast cancer that is estrogen receptor (ER)-positive and human epidermal growth factor receptor 2 (HER2)-negative. Documentation that the member has estrogen receptor (ESR1) mutated disease. Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic Arthritis (PsA): The member must have a documented diagnosis of psoriatic arthritis. Plaque psoriasis (PsO): The member must have a documented diagnosis of plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Oral ulcers associated with Behcet's Disease: The member must have a documented diagnosis of Behcet's Disease. The member has active oral ulcers.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	2 years
Other Criteria	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of neurotrophic keratitis.
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with an ophthalmologist.
Coverage Duration	8 weeks
Other Criteria	None

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) unresectable, locally advanced or metastatic Cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement and has been previously treated or 2) relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following criteria: 1) The member must be a man or postmenopausal woman. 2) The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer. 3) The member has progressed on or after an endocrine-based regimen. 4) Piqray is being used in combination with fulvestrant.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

PIRFENIDONE

Products Affected

- Pirfenidone TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF).
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be a pulmonologist.
Coverage Duration	2 years
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Kaposi Sarcoma: The member must have a documented diagnosis Kaposi sarcoma (KS) or AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART). Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and has received at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (including but not limited to: Kyprolis, Ninlaro, or Velcade) and has demonstrated disease progression on or within 60 days of completion of the last therapy AND Pomalyst is being used in combination with dexamethasone.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with a high-intensity statin (i.e. atorvastatin or rosuvastatin) or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Cardiovascular disease b) Primary hyperlipidemia including Heterozygous Familial Hypercholesterolemia (HeFH) as confirmed by genetic testing or clinical criteria. c) Homozygous Familial Hypercholesterolemia (HoFH) as confirmed by genetic testing or clinical criteria.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

PREVYMIS

Products Affected

- Prevymis TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have documentation of 1) having had, or is scheduled to receive, an allogeneic hematopoietic stem cell transplant (HSCT) and the member is at risk for cytomegalovirus (CMV) infection or 2) having had, or is scheduled to receive, a kidney transplant and the member is at risk for cytomegalovirus (CMV) infection
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

PROLASTIN

Products Affected

- Prolastin-c

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hereditary deficiency of alpha-1 antitrypsin with clinical evidence of emphysema.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Coverage of Prolia (denosumab) for the treatment of osteoporosis in men and postmenopausal women will be authorized when the following criteria are met: 1) The member is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan or 2) the member has had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments [including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)] or 3) the member is a female at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer and is using Prolia (denosumab) as a treatment to increase bone mass. Coverage of Prolia may also be authorized for 1) men at high risk of fracture who are receiving androgen deprivation therapy for non-metastatic prostate cancer or 2) treatment for glucocorticoid-induced osteoporosis in men and women at high risk for fracture.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Immune (idiopathic) Thrombocytopenic Purpura (ITP): The member must have a documented diagnosis of Chronic ITP and has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy. Severe Aplastic Anemia: 1) The member must have a documented diagnosis of severe aplastic anemia and 2) will be taken in combination with, or in those who have had an insufficient response with, standard immunosuppressive therapy. Thrombocytopenia with Chronic Hepatitis C: The member must have a documented diagnosis of thrombocytopenia with chronic hepatitis C infection.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

PYRUKYND

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hemolytic anemia with pyruvate kinase deficiency.
Age Restrictions	None
Prescriber Restrictions	The medication must be prescribed by or in consultation with a hematologist.
Coverage Duration	2 years
Other Criteria	None

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced gastrointestinal stromal tumor (GIST) who have received prior treatment with 3 or more kinase inhibitors, including imatinib.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

QUININE SULFATE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be approved for the treatment or prevention of nocturnal leg cramps.
Required Medical Information	The member is using the medication for treatment of uncomplicated Plasmodium falciparum malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A

RADICAVA ORAL SUSPENSION

Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of amyotrophic lateral sclerosis (ALS).
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	N/A

RELYVRIO

Products Affected

- Relyvrio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	1 year
Other Criteria	N/A

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet the following criteria: 1) Member has an elevated LDL-C level while being treated with a high-intensity statin (i.e. atorvastatin or rosuvastatin) or has an elevated LDL-C level and a contraindication/intolerance to statin therapy. 2) The member must have a documented diagnosis of one of the following: a) Cardiovascular disease b) Primary hyperlipidemia including Heterozygous Familial Hypercholesterolemia (HeFH) as confirmed by genetic testing or clinical criteria. c) Homozygous Familial Hypercholesterolemia (HoFH) as confirmed by genetic testing or clinical criteria.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Non-Small Cell Lung Cancer: The member must have a documented diagnosis of metastatic RET fusion-positive non-small cell lung cancer (NSCLC). RET-mutant Medullary Thyroid Cancer: The member must have a documented diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy. RET Fusion-Positive Thyroid Cancer: The member must have a documented diagnosis of advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be on oncologist.
Coverage Duration	2 years
Other Criteria	None

RETINOIDS FOR THE TOPICAL TREATMENT OF ACNE VULGARIS AND PSORIASIS

Products Affected

- Adapalene CREA
- Adapalene GEL
- Avita
- Retin-a Micro GEL 0.06%
- Retin-a Micro Pump GEL 0.08%
- Tazarotene CREA
- Tazarotene FOAM
- Tazarotene GEL
- Tazorac CREA 0.05%
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage of topical acne products will not be authorized for cosmetic purposes.
Required Medical Information	For all retinoids, the member must have a documented diagnosis of acne vulgaris, comedones (white heads), or actinic keratosis. Tazorac or tazarotene may also be covered if the member has a physician-documented diagnosis of plaque psoriasis or documented diagnosis of skin cancer provided effective treatment with Tazorac or tazarotene is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature.
Age Restrictions	This criterion only applies to members age 26 or older. Authorization is not required for members 25 years of age or younger.
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Follicular Lymphoma (FL): The member must have a documented diagnosis of previously treated FL and the requested drug is being used in combination with a rituximab product. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and the member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib). Marginal Zone Lymphoma (MZL): The member must have a documented diagnosis of previously treated MZL and the requested drug is being used in combination with a rituximab product. Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and the requested drug is being used in combination with dexamethasone or as maintenance therapy in a member following autologous hematopoietic stem cell transplantation. Myelodysplastic Syndrome (MDS): The member must have a documented diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia and documentation cancer has susceptible IDH1 mutation as detected by a Food and Drug Administration-approved test
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chronic graft-versus-host disease and has a failure, contraindication, or intolerance to at least two prior lines of systemic therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Atopic Dermatitis: The member must have a documented diagnosis of moderate to severe atopic dermatitis with 1) a trial and failure of a minimum 30-day supply (or 14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus ointment, Eucrisa (crisaborole) ointment and 2) a trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to, Adbry [tralokinumab-ldrm], Dupixent [dupilumab], etc.). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Rheumatoid Arthritis: The member must 1) have a documented diagnosis of Rheumatoid Arthritis and 2) has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Ulcerative Colitis (UC): The member must 1) have a documented diagnosis UC and 2) has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisone) and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Humira). Non-radiographic Axial Spondyloarthritis: The member must have a document diagnosis of Non-radiographic Axial Spondyloarthritis and has an inadequate response or intolerance to TNF blocker therapy.
Age Restrictions	None

Prescriber Restrictions	Prescribed by or in consultation with a allergist/immunologist, dermatologist, gastroenterologist, or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic NSCLC with ROS1-positive tumors. Solid Tumors: The member must have a documented diagnosis of solid tumors that 1) have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, 2) are metastatic or where surgical resection is likely to result in severe morbidity, and 3) have progressed following treatment or have no satisfactory alternative therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Rubraca will not be approved for concurrent use with other chemotherapy agents.
Required Medical Information	Recurrent Ovarian Cancer (maintenance): The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and is in a complete or partial response to platinum-based chemotherapy. Prostate Cancer: The member must have a documented diagnosis of deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor directed therapy and a taxane-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Rydapt will not be approved as single-agent induction therapy for the treatment of patients with AML.
Required Medical Information	Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML that is FLT3 mutation-positive and Rydapt is being used as first-line therapy in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Mast Cell Leukemia (MCL): The member must have a documented diagnosis of MCL. Systemic Mastocytosis: The member must have a documented diagnosis of aggressive systemic mastocytosis (ASM) or systemic mastocytosis with associated hematological neoplasm (SM-AHN).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

SAPROPTERIN

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a specialist in metabolic diseases or a geneticist.
Coverage Duration	Initial authorization is for 8 weeks. Subsequent authorization is for 2 years.
Other Criteria	Coverage will be authorized for continuing therapy if the member has experienced improvement.

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) and previously treated with two or more tyrosine kinase inhibitors (TKIs) or has a documented T315I mutation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Cushing's disease and pituitary surgery is not an option or has not been curative.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	2 years
Other Criteria	None

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB) and Sirturo is being used in combination with at least three other drugs to which the member's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, treatment may be initiated with Sirturo in combination with at least four other drugs to which the member's MDR-TB isolate is likely to be susceptible.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

SKYRIZI

Products Affected

- Skyrizi
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist.
Coverage Duration	2 years
Other Criteria	None

SODIUM OXYBATE

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of narcolepsy with cataplexy or excessive daytime sleepiness (EDS).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acromegaly and has had a failure of, or is unable to tolerate, a treatment regimen that includes octreotide, and the member is not a candidate for or has had an inadequate response to surgery and/or radiation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	2 years
Other Criteria	None

SORAFENIB

Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Hepatocellular Carcinoma (HCC): The member must have a documented diagnosis of biopsy-proven, unresectable HCC. Thyroid Carcinoma (TC): The member must have a documented diagnosis of locally recurrent or metastatic, progressive, differentiated TC refractory to radioactive iodine treatment.
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be a nephrologist, oncologist, or urologist.
Coverage Duration	2 years
Other Criteria	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Myeloid Leukemia (CML): 1) The member must have a documented diagnosis of Philadelphia chromosome-positive (Ph+) CML in chronic phase or 2) The member has a documented diagnosis of chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL): The member must have a documented diagnosis of Ph+ALL and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). For Pediatric Members: The member must have a documented diagnosis of Ph+CML in chronic phase or the member has Ph+ALL and Sprycel is being used in combination with chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

STELARA

Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Crohn's Disease (CD): The member must have a documented diagnosis CD and a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisone, or methotrexate. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe plaque psoriasis and has failed to respond to or has been unable to tolerate treatment with one of the following: Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, or Coal tar. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis. Ulcerative Colitis (UC): The member must have a documented diagnosis UC and has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisone).
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, gastroenterologist or rheumatologist.
Coverage Duration	2 years
Other Criteria	None

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Gastrointestinal Stromal Tumors (GIST): The member must have a documented diagnosis of GIST and documented failure, contraindication, or intolerance to both imatinib mesylate (Gleevec) and Sutent (sunitinib malate). Hepatocellular Carcinoma: The member must have a documented diagnosis of hepatocellular carcinoma and had a documented failure, contraindication, or intolerance to Nexavar (sorafenib). Metastatic Colorectal Cancer (MCC): The member must have a documented diagnosis of MCC and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if RAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

SUNITINIB

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of GIST and has a demonstrated disease progression or intolerance with imatinib mesylate (Gleevec). Progressive Neuroendocrine Tumors (pNET): The member must have a documented diagnosis of unresectable, locally advanced, or metastatic pNET located in the pancreas. Recurrent Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of recurrent RCC following nephrectomy and Sunitinib is being used as adjuvant therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be approved for generalized fatigue, jet lag, or sleep-deprivation not associated with a covered diagnosis.
Required Medical Information	The member must have a documented diagnosis of excessive daytime sleepiness associated with either narcolepsy or obstructive sleep apnea (OSA).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF), who are homozygous for the F508del mutation or have one mutation in the CFTR gene that is responsive to Symdeko based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bidirectional sequencing when recommended by the mutation test instructions for use.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) with a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TADALAFIL

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Tadalafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	The member must have a documented diagnosis or signs and symptoms of Benign Prostatic Hyperplasia (BPH) and has had a documented failure, adverse reaction, or contraindication to a 30-day trial of at least two of the following medications: alfuzosin, doxazosin, dutasteride, dutasteride-tamsulosin, finasteride, tamsulosin, or terazosin.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Tafinlar is not indicated for the treatment of patients with wild-type BRAF mutations.
Required Medical Information	Single Agent: The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E mutation. In Combination with Mekinist: The member must have a documented diagnosis of one of the following: 1) Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. 2) Melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection. 3) Metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation. 4) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with a BRAF V600E mutation with no satisfactory locoregional treatment options. 5) Unresectable or metastatic solid tumors with BRAF V600E mutation and has progressed following prior treatment. 6) low grade glioma with BRAF V600E mutation that requires systemic therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations OR 2) metastatic EGFR T790M mutation-positive NSCLC whose disease has progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy (including but not limited to: Gilotrif, Iressa, Tarceva) or 3) NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations and Tagrisso is being used as adjuvant therapy after tumor resection.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) deleterious or suspected deleterious germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer or 2) HRR gene-mutated metastatic castration-resistnant prostrate cancer (mCRPC) and is being used in combination with enzalutamide.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase (Ph+ CML-CP): The member must have a documented diagnosis of Ph+ CML in chronic phase and the requested drug is being used as initial therapy. Resistant or Intolerant Ph+ CML-CP and CML-AP: The member must have a documented diagnosis of Ph+ CML in chronic phase or accelerated phase and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). Pediatric Patients: The member must have a documented diagnosis of 1) Ph+ CML in chronic phase and is newly diagnosed or 2) Ph+ CML in chronic or accelerated phase and has a resistance or intolerance to prior tyrosine-kinase inhibitor (TKI) therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

TASIMELTEON

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will not be authorized for the diagnosis of insomnia.
Required Medical Information	The member must have a documented diagnosis of Smith-Magenis Syndrome (SMS) and be experiencing nighttime sleep disturbances or the member must be completely blind and have a documented diagnosis of non-24-hour sleep-wake disorder (non-24).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist or sleep specialist.
Coverage Duration	2 years
Other Criteria	None

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) and the requested drug is being used in combination with standard therapy including glucocorticoids.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have one of the following requirements: 1) The member must have a documented diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection. 2) The member must have a documented diagnosis of relapsed or refractory follicular lymphoma whose tumors are positive for an EZH2 mutation and has received at least two prior systemic therapies. 3) The member must have a documented diagnosis of relapsed or refractory follicular lymphoma who have no satisfactory alternative treatment options.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TERIPARATIDE

Products Affected

- Teriparatide INJ 620MCG/2.48ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage for teriparatide will not be authorized when cumulative use of it and/or other parathyroid hormone analogs is greater than 2 years.
Required Medical Information	The requesting physician must provide documentation that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments (including but not limited to: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast)).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Cumulative lifetime therapy with teriparatide should not exceed 2 years.
Other Criteria	None

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chorea associated with Huntington's Disease.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Relapsed or Refractory Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of relapsed or refractory AML with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, Tibsovo is being used as first-line therapy, and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy. Cholangiocarcinoma: The member must have a documented diagnosis of locally advanced or metastatic cholangiocarcinoma who have been previously treated.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

TRANSMUCOSAL IMMEDIATE-RELEASE FENTANYL (TIRF)

Products Affected

- Fentanyl Citrate TABS
- Fentanyl Citrate Oral Transmucosal
- Lazanda SOLN 100MCG/ACT, 400MCG/ACT
- Subsys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	The Transmucosal Immediate-Release Fentanyl (TIRF) products will not be covered for any non-cancer pain indication.
Required Medical Information	The Transmucosal Immediate-Release Fentanyl (TIRF) products will be covered for the management of breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. (applies to Fentanyl lozenges only) Approvable for pediatric patients 16 years of age and older.
Age Restrictions	None.
Prescriber Restrictions	The prescribing physician must be an oncologist or a pain management specialist.
Coverage Duration	2 years
Other Criteria	Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of, but not limited to, morphine oral 60 mg daily or more, fentanyl transdermal 25 mcg/hour or more, oxycodone oral 30 mg daily or more, hydromorphone oral 8 mg daily or more, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids when taking fentanyl transmucosal.

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) with at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive based on in vitro data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TRUQAP

Products Affected

- Truqap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations. One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A

TRUSELTIQ

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting and be taking in combination with trastuzumab and capecitabine or 2) RAS wild-type HER-2 positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy and be taking in combination trastuzumab.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and the condition is not amenable to improvement with surgery.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage for Tymlos will not be authorized when cumulative use of it and/or other parathyroid hormone analogs is greater than 2 years.
Required Medical Information	The member must be a postmenopausal woman or man with a documented diagnosis of osteoporosis. The requesting physician must provide documentation that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Coverage of Tymlos is limited to 24 months.
Other Criteria	None

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of migraines and has had an inadequate response, intolerance, or contraindication to at least one triptan medication.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

VALTOCO

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of a seizure disorder requiring acute treatment.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	2 years
Other Criteria	None

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of newly diagnosed Acute Myeloid Leukemia (AML) that is FLT3 internal tandem duplication (ITD) positive as detected by an FDA approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Acute Myeloid Leukemia (AML): The member must have a documented diagnosis of AML and the requested drug is being used as first-line therapy in combination with azacitidine, decitabine, or low-dose cytarabine and the member meets one of the following: 1) is 75 years of age or older or 2) has comorbidities that make them ineligible for intensive induction chemotherapy. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of CLL or SLL.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	For Monotherapy: The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy. For Combination Therapy with Faslodex (fulvestrant): The member must have a documented diagnosis of HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy. For Combination Therapy with an Aromatase Inhibitor as initial endocrine-based therapy: The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer. Combination with Endocrine Therapy (tamoxifen or an aromatase inhibitor): The member must have a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, advanced or metastic breast cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

VIJOICE

Products Affected

- Vijoice

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic or surgically unresectable neurotrophic receptor tyrosine kinase (NTRK) gene fusion-positive solid tumors with no known acquired resistance mutation and with no satisfactory alternative treatments or the member has progressed following treatment.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) in tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count less than 50 × 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	N/A

VORICONAZOLE FOR IV INJECTION

Products Affected

- Voriconazole INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) infection caused by Aspergillus or Candida, including candidemia or other serious invasive candidiasis infection, invasive aspergillosis, CNS infection (i.e. meningitis), cardiovascular system infection (i.e. endocarditis, myocarditis, pericarditis, infected pacemaker, implantable cardiac defibrillator, or ventricular assist devices), esophageal candidiasis, invasive pulmonary aspergillosis and other Aspergillus respiratory infection (i.e. pneumonia, tracheobronchitis, sinusitis, aspergilloma), intrabdominal infections, bone and joint infection, fungal skin and skin structure infection or 2) serious fungal infection caused by Scedosporium apiospermum or Fusarium and intolerant of, or refractory to, other therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	None

VOTRIENT

Products Affected

- Pazopanib Hydrochloride
- Votrient

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (RCC): The member must have a documented diagnosis of advanced RCC. Advanced Soft Tissue Sarcoma (STS): The member must have a documented diagnosis of advanced STS and has received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

VOXZOGO

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of achondroplasia with open epiphyses.
Age Restrictions	The member must be 5 to 17 years of age
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist.
Coverage Duration	2 years
Other Criteria	None

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist.
Coverage Duration	2 years
Other Criteria	None

VYVANSE

Products Affected

- Lisdexamfetamine Dimesylate
- Vyvanse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Attention Deficit Hyperactivity Disorder (ADHD): The member must have a documented diagnosis of ADHD and has failed or has had an inability to tolerate 2 or more generic medications indicated for ADHD. Binge Eating Disorder (BED): The member must have a documented diagnosis of moderate to severe BED.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of von Hippel-Lindau disease and require therapy for associated renal cell carcinoma, CNS hemangioblastomas, or pancreatic neuroendocrine tumors, not requiring immediate surgery.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

WINLEVI

Products Affected

- Winlevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage of topical acne products will not be authorized for cosmetic purposes.
Required Medical Information	The member must have a documented diagnosis of acne vulgaris.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of 1) metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive or the member has documented ROS1-positive tumors, 2) relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive, or 3) unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT) that is ALK-positive.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

XDEMVY

Products Affected

- Xdemvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have a documented diagnosis of Demodex blepharitis.
Age Restrictions	N/A
Prescriber Restrictions	The medication must be prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	2 years.
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Ankylosing spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Rheumatoid Arthritis (RA): The member must 1) have a documented diagnosis of RA and 2) has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must 1) have a documented diagnosis of PJIA and 2) has a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: methotrexate, leflunomide, or sulfasalazine and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira). Ulcerative Colitis (UC): The member must 1) have a documented diagnosis of UC and 2) has a trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), sulfasalazine], azathioprine, or corticosteroids (e.g., prednisone, methylprednisone) and 3) has an inadequate response or intolerance to one or more TNF inhibitors (e.g., Humira).
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or rheumatologist.
Coverage Duration	2 years

Other Criteria	None

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of carcinoid syndrome diarrhea that is inadequately controlled by somastatin analog (SSA) therapy alone and Xermelo is being used in combination with an SSA (e.g. Sandostatin LAR).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hematologist, or oncologist.
Coverage Duration	2 years
Other Criteria	None

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Coverage for Xgeva (denosumab) will be authorized if one of the following is met: 1) for prevention of skeletal-related events in patients with multiple myeloma or with bone metastases from solid tumors 2) the member is being treated for unresectable giant cell tumor of bone (GCTB) or surgical resection of GCTB is likely to result in severe morbidity 3) for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

XIFAXAN 550 MG

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Hepatic Encephalopathy: The member must have a documented diagnosis of hepatic encephalopathy and has had an inadequate response or a contraindication to lactulose. Irritable Bowel Syndrome with Diarrhea (IBS-D): The member must have a documented diagnosis of IBS-D.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	None

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Asthma: The member must 1) have a documented diagnosis of moderate-to-severe persistent asthma 2) has had a failure of a treatment regimen that included two or more of the following medications: inhaled corticosteroids, oral corticosteroids, leukotriene modifiers and inhaled long-acting bronchodilators, or is unable to tolerate these medications. 3) shows a definitive sensitivity on allergy testing to one or more perennial allergens and 4) The member has a pre-treatment serum IgE level equal to or greater than 30 IU/mL and less than or equal to 1,300 IU/mL. Chronic Spontaneous Urticaria (CSU): 1) The member has a documented diagnosis of CSU and 2) the physician has documented that the member remains symptomatic despite H1 antihistamine treatment. Nasal polyps: The member must have a documented diagnosis of nasal polyps with inadequate response to nasal corticosteroids.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist.
Coverage Duration	2 years
Other Criteria	None

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

XPOVIO

Products Affected

- Xpovio
- Xpovio 100 Mg Once Weekly
- Xpovio 40 Mg Once Weekly
- Xpovio 40 Mg Twice Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	In combination with dexamethasone: The member must meet ALL of the following criteria: 1) Documented diagnosis of relapsed or refractory multiple myeloma. 2) Has received at least four prior therapies. 3) The member's disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. In combination with (Velcade) bortezomib and dexamethasone: The member must have a documented diagnosis of multiple myeloma and has received at least one prior therapy. Relapsed or Refractory Diffuse Large B-cell Lymphoma (DLBCL): The member must have a documented diagnosis of DLBCL, not otherwise specified, including DLBCL arising from follicular lymphoma, and has received at least 2 lines of systemic therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic castration-resistant prostate cancer (CRPC) and is being used in combination with methylprednisolone.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	2 years
Other Criteria	None

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must meet one of the two following requirements: 1) The member must have a documented diagnosis of advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and is experiencing complete or partial response to platinum-based chemotherapy 2) The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer with a deleterious or suspected deleterious germline BRCA mutation and who are in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.
Required Medical Information	Erdheim-Chester Disease (ECD): The member must have a documented diagnosis of ECD with a BRAF V600 mutation. Unresectable or Metastatic Melanoma: The member must have a documented diagnosis of unresectable or metastatic melanoma that is BRAF V600E mutation-positive.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cutaneous T-cell lymphoma (Stage IIB and higher) and progressive, persistent or recurrent disease and documented current or prior treatment or treatment failure with at least two systemic chemotherapeutic agents for cutaneous T-cell lymphoma.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The member must have 1) a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) and 2) a trial and failure, contraindication, or intolerance to two formulary anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	2 years
Other Criteria	N/A

ZURZUVAE

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): Diagnosis of postpartum Depression
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	Chronic Lymphocytic Leukemia (CLL): The member must have a documented diagnosis of relapsed CLL and Zydelig is being used in combination with Rituxan (rituximab).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	None

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	2 years
Other Criteria	None

PART B VERSUS PART D

Products Affected

- Acetylcysteine SOLN
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 405MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 750MG/100ML
- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 300MG/100ML; 570MG/100ML; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Aprepitant CAPS
- Arformoterol Tartrate
- Azathioprine TABS
- Bivigam INJ 10%, 5GM/50ML
- Budesonide SUSP
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 8/10
- Clinisol Sf 15%
- Cromolyn Sodium NEBU
- Cuvitru
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Flebogamma Dif
- Formoterol Fumarate NEBU
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML

- Gammagard Liquid
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Heplisav-b
- Hizentra
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Jylamvo
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Methotrexate INJ 50MG/2ML
- Methotrexate Sodium INJ 1GM/40ML, 250MG/10ML, 50MG/2ML
- Methotrexate Sodium TABS
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nutrilipid
- Octagam
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Panzyga
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Privigen
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trexall

- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Xatmep
- Yupelri

Details

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

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