# ABIRATERONE

## Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC) OR metastatic high-risk castration-sensitive prostate cancer (CSPC). Abiraterone will be used in combination with prednisone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ACTEMRA SC

## Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one adalimumab product, Orencia (abatacept), Rinvoq, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. |

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| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ADALIMUMAB-AATY

## Products Affected

- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. |

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|---|---|
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist. |
| **Coverage Duration** | UC (Initial): 12 wks,(reauth): Plan Year. All other indications (initial): 6 mo, (reauth): Plan Year |

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|---|---|
| **Other Criteria** | Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or improvement in signs and symptoms of the disease (may include reduction in stool frequency/bloody stools, improvement abdominal pain, or endoscopic response) by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |

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| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ADALIMUMAB-ADBM

## Products Affected

- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |

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|---|---|
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist. |
| **Coverage Duration** | UC (Initial): 12 wks,(reauth): Plan Year. All other indications (initial): 6 mo, (reauth): Plan Year |

| | |
|---|---|
| **Other Criteria** | Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or improvement in signs and symptoms of the disease (may include reduction in stool frequency/bloody stools, improvement abdominal pain, or endoscopic response) by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |

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| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ADEMPAS

## Products Affected

- Adempas

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.) |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AIMOVIG

## Products Affected

- Aimovig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of either episodic migraines or chronic migraines. For episodic migraine, patient must have both of the following: less than 15 headache days per month and 4-14 migraine days per month. For chronic migraine, patient must have both of the following: at least 15 headache days per month and at least 8 migraine days per month. Patient has had a trial and failure or contraindication to at least 2 different preventative migraine medications. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist |
| **Coverage Duration** | Initial: 3 months. Renewal: plan year. |
| **Other Criteria** | For renewal, patient must have a positive clinical response. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# AKEEGA

## Products Affected

- Akeega

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC). And will be used in combination with prednisone. And will be used in combination with a gonadotropin-releasing hormone (GnRH) analog OR patient has had a bilateral orchiectomy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ALECENSA

## Products Affected

- Alecensa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of metastatic non-small cell lung cancer (NSCLC) with anaplastic lymphoma kinase (ALK) positive disease as detected by an FDA approved test OR Patient has a diagnosis of NSCLC AND using as adjuvant treatment following tumor resection AND tumor is ALK-positive as detected by an FDA approved test AND tumors greater than or equal to 4 cm or node positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ALPHA1 PROTEINASE INHIBITOR

## Products Affected

- Aralast Np INJ 500MG
- Prolastin-c INJ 1000MG/20ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry), unless the patient has a concomitant diagnosis of necrotizing panniculitis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ALUNBRIG

## Products Affected

- Alunbrig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AMBRISENTAN

## Products Affected

- Ambrisentan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Patient has a diagnosis of pulmonary arterial hypertension (WHO Group I). For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ARMODAFINIL

## Products Affected

- Armodafinil

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder. |
| **Age Restrictions** | 17 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# AUBAGIO

## Products Affected

- Teriflunomide

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Severe hepatic impairment. Pregnancy. Concomitant use with leflunomide or another disease-modifying therapy for MS. |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Serum transaminase and bilirubin levels must be drawn within 6 months prior to initiation of therapy with teriflunomide. For female patients of childbearing potential: Pregnancy was excluded prior to initiation of therapy and patient will use reliable contraception during treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AUGTYRO

## Products Affected

- Augtyro

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dx of locally advanced or metastatic ROS1-positive non-small cell lung cancer in adults OR Patient has a diasnosis of a solid tumors AND a neurotrophic tyrosine receptor kinase (NTRK) gene fusion AND tumors are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity AND cancer has progressed following treatment or have no satisfactory alternative therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AURYXIA

## Products Affected

- Auryxia
- Ferric Citrate TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Auryxia will not be approved for a diagnosis of iron deficiency anemia. |
| **Required Medical Information** | Patient has a diagnosis of hyperphosphatemia. Patient has chronic kidney disease and is on dialysis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Subject to ESRD review. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AUSTEDO

## Products Affected

- Austedo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. Concomitant tetrabenazine (Xenazine). |
| **Required Medical Information** | Patient has a diagnosis of chorea associated with Huntington's disease OR has a diagnosis of tardive dyskinesia clinically diagnosed with all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# AVACOPAN

## Products Affected

- Tavneos

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Avacopan will be used as an adjunctive treatment for severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)) in combination with standard therapy including glucocorticoids. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# AVMAPKI FAKZYNJA

**Products Affected**

- Avmapki Fakzynja Co-pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC) AND has a KRAS mutation AND has received a prior systemic therapy |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# AYVAKIT

## Products Affected

- Ayvakit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has unresectable or metastatic gastrointestinal stromal tumors (GIST) with a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Patient has a diagnosis of advanced systemic mastocytosis including patients with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, and mast cell leukemia OR indolent systemic mastocytosis AND patient has a platelet count greater than 50,000/mm3. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# BALVERSA

## Products Affected

- Balversa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). Disease is one of the following: Locally advanced or Metastatic. Presence of susceptible fibroblast growth factor receptor (FGFR) 3 genetic alterations as detected by an U.S. Food and Drug Administration (FDA)-approved test (therascreen FGFR RGQ RT-PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed on or after at least one line of prior systemic therapy (e.g., chemotherapy). One of the following: 1) Patient had been treated with prior PD-1 inhibitor (e.g., Opdivo [nivolumab], Keytruda [pembrolizumab]) or PD-L1 inhibitor therapy (e.g., Bavencio [avelumab]) or 2) Patient is not a candidate for PD-1 or PD-L1 inhibitor therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# BENLYSTA

## Products Affected

- Benlysta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Severe active CNS lupus, or use of Benlysta in combination with other biologics, including B-cell targeted therapies or intravenous (IV) cyclophosphamide |
| **Required Medical Information** | Patient has active, autoantibody-positive systemic lupus erythematosus (SLE) and is receiving standard therapy (corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or is not on standard therapy due to past trial and inadequate response or intolerance. Patient has a diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | SLE (init): Prescribed by or in consultation with a rheumatologist. Lupus Nephritis (init): Prescribed by or in consultation with a nephrologist or rheumatologist. |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | SLE, Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# BESREMI

**Products Affected**

- Besremi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of polycythemia vera as confirmed by one of the following: A) All of the following: 1) One of the following: a) Hemoglobin greater than 16.5 g/dL for men or hemoglobin greater than 16.0 g/dL for women or b) Hematocrit greater than 49% for men or hematocrit greater than 48% for women AND 2) Bone marrow biopsy showing age-adjusted hypercellularity with trilineage growth (panmyelosis) including prominent erythroid, granulocytic and megakaryocytic proliferation with pleomorphic, mature megakaryocytes (differences in size), AND 3) One of the following: a) Presence of JAK2 V617F or JAK2 exon 12 mutation or b) Subnormal serum erythropoietin level, OR B) All of the following: 1) Patient with sustained absolute erythrocytosis as demonstrated by one of the following: a) Hemoglobin greater than 18.5 g/dL for men or greater than 16.5 g/dL for women, or b) Hematocrit greater than 55.5% for men or greater than 49.5% for women, AND 2) Presence of JAK2 V617F or JAK2 exon 12 mutation, AND 3) Subnormal serum erythropoietin level. For high-risk polycythemia vera only (patient greater than or equal to 60 years old and/or prior thrombosis history), trial and inadequate response, contraindication or intolerance to hydroxyurea. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# BEXAROTENE

## Products Affected

- Bexarotene CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of cutaneous T-cell lymphoma and is refractory to at least 1 prior systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# BOSENTAN

## Products Affected

- Bosentan TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN). |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment |
| **Age Restrictions** | Age 3 and older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# BOSULIF

## Products Affected

- Bosulif

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic (newly diagnosed or previously treated), accelerated, or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML). For a diagnosis of accelerated phase or blast phase, patient had resistance or intolerance to prior treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# BPH VS ED

## Products Affected

- Tadalafil TABS 2.5MG, 5MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Not covered for the treatment of Erectile Dysfunction. Maximum dose: 5mg daily |
| **Required Medical Information** | Patient must have a diagnosis of BPH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# BRAFTOVI

**Products Affected**

- Braftovi CAPS 75MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For a diagnosis of unresectable or metastatic melanoma: patient has a BRAF V600E or V600K mutation, will be used in combination with binimetinib (Mektovi), patient was not previously treated with a BRAF inhibitor or MEK inhibitor. For a diagnosis of metastatic colorectal cancer: patient has a BRAF V600E mutation, will be used in combination with cetuximab, patient has been on prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# BRUKINSA

## Products Affected

- Brukinsa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of mantle cell lymphoma and has received at least 1 prior therapy. Patient has a diagnosis of Waldenstrom's macroglobulinemia (WM). Patient has a diagnosis of relapsed or refractory marginal zone lymphoma (MZL) and has received at least one anti-CD20-based regimen. Patient has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Patient has a diagnosis of relapsed or refractory follicular lymphoma (FL) AND will be used in combination with obinutuzumab AND patient has recieved two or more lines of systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# CABOMETYX

## Products Affected

- Cabometyx

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma (RCC) and meets one of the following: will be used as monotherapy OR will be used in combination with nivolumab for first-line treatment. Patient has a diagnosis of advanced hepatocellular carcinoma and has been previously treated with sorafenib (Nexavar). Patient has a diagnosis of differentiated thyroid cancer that is locally advanced or metastatic and has progressed following prior VEGFR- targeted therapy (eg. Lenvima, Nexavar) and is radioactive iodine-refractory or ineligible. Patient has a diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET). Patient has a diagnosis of previously treated, unresectable, locally advanced or metastatic, well-differentiated extra-pancreatic neuroendocrine tumors (epNET). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# CALQUENCE

**Products Affected**

- Calquence

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL). One of the following: A) All of the following: 1) Patient has received no prior therapy for MCL (e.g., bortezomib, rituximab), 2) Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) Used in combination with bendamustine and rituximab, OR B) Patient has received at least one prior therapy for MCL. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# CAPLYTA

## Products Affected

- Caplyta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: asenapine, aripiprazole, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, ziprasidone. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate. Trial and failure, contraindication, or intolerance to quetiapine (IR or ER) or olanzapine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Approve for continuation of prior therapy |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# CAPRELSA

## Products Affected

- Caprelsa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Patient has congenital long QT syndrome. |
| **Required Medical Information** | Patient has a diagnosis of symptomatic or progressive medullary thyroid cancer. Patient has unresectable locally advanced or metastatic disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# CINRYZE

**Products Affected**

- Cinryze

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an allergist or immunologist or another physician that specializes in the treatment of hereditary angioedema |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks. |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# COBENFY

## Products Affected

- Cobenfy
- Cobenfy Starter Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of schizophrenia AND trial and failure, contraindication, or intolerance to one oral generic formulary atypical antipsychotic agents (ex. aripiprazole, asenapine, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, or ziprasidone). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Approve for continuation of prior therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# COMETRIQ

## Products Affected

- Cometriq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of progressive, metastatic, medullary thyroid cancer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# COPIKTRA

## Products Affected

- Copiktra

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease is relapsed or refractory. Trial and failure, contraindication, or intolerance to at least two prior therapies for CLL/SLL (e.g., Leukeran [chlorambucil], Gazyva [obinutuzumab], Arzerra [ofatumumab], Bendeka [bendamustine], Imbruvica [ibrutinib], Rituxan [rituximab], etc.). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, 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.) Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS. |
| **Age Restrictions** | N/A |

| | |
|---|---|
| **Prescriber Restrictions** | Plaque psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# COTELLIC

## Products Affected

- Cotellic

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Cobimetinib will be used in combination with vemurafenib (Zelboraf). Patient has a diagnosis of histiocytic neoplasms. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# CRESEMBA ORAL

## Products Affected

- Cresemba CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Fungal infection: Diagnosis of invasive aspergillosis or invasive mucormycosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# CTEXLI

## Products Affected

- Ctexli

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Initial: Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease). Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Initial: Prescribed by or in consultation with one of the following: a) Neurologist, b) Geneticist, or c) Metabolic disease specialist |
| **Coverage Duration** | Initial: 12 months. Reauth: 12 months. |
| **Other Criteria** | Reauth: Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DALFAMPRIDINE

**Products Affected**

- Dalfampridine Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min) and/or history of seizures. |
| **Required Medical Information** | Patient must have the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine. Patient has a diagnosis of multiple sclerosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | To continue therapy, the patient must experience improvement in walking speed or other objective measure of walking ability since starting dalfampridine. Dalfampridine at doses exceeding 10mg twice daily are not covered. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DANZITEN

## Products Affected

- Danziten

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DAURISMO

**Products Affected**

- Daurismo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of acute myeloid leukemia (AML) and is newly diagnosed. Daurismo (glasdegib) will be used in combination with low-dose cytarabine. Patient is 75 years old or older OR has comorbidities that precludes the use of intensive induction chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DEFERASIROX

## Products Affected

- Deferasirox

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Patients with an eGFR less than 40mL/min/1.73m2. Patient's with a platelet count less than 50 million/L. |
| **Required Medical Information** | Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DEFERIPRONE

## Products Affected

- Deferiprone

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of transfusion-related iron overload due to thalassemia syndromes or a diagnosis of sickle cell anemia or other anemias. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DIACOMIT

## Products Affected

- Diacomit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of seizures associated with Dravet syndrome. Patient will be on stiripentol with clobazam. |
| **Age Restrictions** | Patient is 6 months of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DICLOFENAC

## Products Affected

- Diclofenac Sodium GEL 3%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of actinic keratosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DICLOFENAC SOLUTION

## Products Affected

- Diclofenac Sodium EXTERNAL SOLN 1.5%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# DUPIXENT

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |

| | |
|---|---|
| **Required Medical Information** | Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-tx) peripheral blood eosinophil level greater than or equal to 150 cells/ml. One of the following: 1) Pt has had 2 or more asthma exacerbations requiring systemic corticosteroids (CS) (eg, prednisone) w/in the past 12 mo, 2) Prior asthma-related hospitalization w/in the past 12 mo. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Pt is currently dependent on oral CS for the treatment of asthma. EA, CDA (init): One of the following: 1) Both of the following: a) Pt is at least 6 yo but less than 12 yo b) Pt is currently being treated w/ 1 of the following unless there is a contraindication or intolerance (C/I) to these meds: i) Medium-dose inhaled corticosteroid (ICS) (eg, greater than 100–200mcg fluticasone propionate equivalent/day) and Additional asthma controller med (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) or ii) 1 medium dosed combo ICS/LABA product (eg, fluticasone propionate 100mcg/salmeterol50mcg, budesonide80mcg/formoterol4.5mcg, fluticasone furoate 50mcg/vilanterol 25mcg) OR 2) Pt is at least 12 yo and Pt is currently being treated w/ 1 of the following unless there is a C/I to these meds: a) Both of the following: i) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller med, OR b) 1 maximally-dosed combo ICS/LABA product [eg, fluticasone propionate 500mcg/salmeterol50mcg, budesonide160mcg/formoterol4.5mcg, fluticasone200mcg/vilanterol25mcg]. Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Dx of CRSwNP. Unless contraindicated, the pt has had an inadequate response to 2 mo of tx with an intranasal CS (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. |
| **Age Restrictions** | Asthma (initial): Patient is 6 years of age or older. AD (initial): Patient is 6 months or age or older. CRSwNP, PN: no age restriction. EoE (initial): Patient is at least 1 year of age. |
| **Prescriber Restrictions** | AD, PN (Init): Prescribed/consult with a dermatologist or allergist/immunologist. Asthma (init, reauth): Prescribed/consult with a pulmonologist or allergist/immunologist. AFRS (init), CRSwNP (init, reauth): Prescribed/consult with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (init): Prescribed/consult with a gastroenterologist or allergist/immunologist. COPD (init, reauth): Prescribed/consult with a pulmonologist. |

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|---|---|
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | Eosinophilic esophagitis (EoE) (init): Dx of EoE. Pt has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, GERD/heartburn symptoms, chest pain, abdominal pain). Pt has at least 15 intraepithelial eosinophils per high power field. Other causes of esophageal eosinophilia have been excluded. Pt weighs at least 15 kg. Trial and failure, contraindication, or intolerance (TF/C/I) to at least an 8-wk trial of 1 of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) CS (eg, budesonide, fluticasone). PN (init): Dx of PN. Atopic dermatitis (AD) (init): Dx of mod to severe AD. 1 of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing AD (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for TCS), CI (eg, safety concerns, not indicated for pt's age/wt), or intol to 1 of the following: a) Medium or higher potency TCS, b) Pimecrolimus, c) Tacrolimus ointment, or d) crisaborole. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of type 2 inflammation evidenced by baseline blood eosinophils greater than or equal to 300 cells/mcL. Pt is receiving 1 of the following at maximally tolerated doses: triple therapy [ie, an ICS, a LAMA, and a LABA] OR if CI to ICS, a LAMA and a LABA. Pt has had at least 2 exacerbations where systemic CS [IM/IV/oral] were required at least once OR COPD-related hospitalization w/in the past 12 mo. Bullous Pemphigoid (BP) (init): Dx of BP as confirmed by skin biopsy or serology. Will be used in combo w/ a tapering course of oral CS until disease control has occurred. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction in BSA involvement or SCORAD index value from baseline. AFRS, EA, CDA, PN, CRSwNP, COPD, BP (reauth): Pt demonstrates positive clinical response to therapy. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement of 1 of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures). COPD (reauth): Pt cont on triple therapy (ie, an ICS, a LAMA, and a LABA) OR if CI to ICS, a LAMA and a LABA. Chronic Spontaneous Urticaria (CSU) (init): Dx of CSU. Persistent symptoms (itching and hives) with a 2nd generation H1 antihistamine (H1A) (eg, cetirizine, fexofenadine), unless C/I to H1A. Used concurrently with an H1A unless C/I to H1A. CSU (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction from baseline in itching severity or number of hives. Allergic Fungal Rhinosinusitis (AFRS) (init): Dx of AFRS. Pt has history of sino-nasal surgery. |

| | |
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| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ENBREL

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. |
| **Age Restrictions** | N/A |

| | |
|---|---|
| **Prescriber Restrictions** | RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ENDARI

## Products Affected

- L-glutamine PACK

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. Patient has had 2 or more painful sickle cell crises within the past 12 months. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ENSACOVE

## Products Affected

- Ensacove

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | Some FDA-approved Indications Only. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of non-small cell lung cancer (NSCLC) AND tumor is ALK positive AND disease is locally advanced or metastatic AND patient has not previously received an ALK-inhibitor [e.g. Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), Xalkori (crizotinib), Zykadia (ceritinib)] |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# EPCLUSA

## Products Affected

- Epclusa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# EPIDIOLEX

## Products Affected

- Epidiolex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# EPKINLY

## Products Affected

- Epkinly

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma in adults. And patient has had 2 or more lines of systemic therapy. OR patitent has a dx of relapsed or refractory follicular lymphoma and has had 2 or more lines of systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# EPOETIN

## Products Affected

- Procrit
- Retacrit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Determine if ESRD (B vs D) Patient has one of the following diagnosis: anemia associated with chronic renal failure, anemia associated with chemotherapy, Anemia secondary to zidovudine in HIV-infected patients, Reduction of allogeneic RBC transfusion in patients undergoing elective, non cardiac, non vascular surgery |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ERIVEDGE

## Products Affected

- Erivedge

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic basal cell carcinoma OR has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ERLEADA

## Products Affected

- Erleada

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has non-metastatic, castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer. Patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ERLOTINIB

## Products Affected

- Erlotinib Hydrochloride TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pancreatic cancer: Used first-line in locally advanced, unresectable, or metastatic cancer in combination with gemcitabine. For metastatic non-small cell lung cancer: not used in combination with platinum-based chemotherapy, tumors have EGFR exon 19 deletions or exon 21 substitution mutations. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ESBRIET

## Products Affected

- Pirfenidone

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage and  Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# EVEROLIMUS

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of progressive pancreatic neuroendocrine tumors (pNET) that are unresectable OR progressive, well-differentiated, nonfunctional GI or lung endocrine tumors in patients with unresectable, locally advanced or metastatic disease OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of tuberous sclerosis complex (TSC)-associated partial-onset seizures. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# EXKIVITY

## Products Affected

- Exkivity

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# FASENRA

## Products Affected

- Fasenra
- Fasenra Pen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR 2) Prior asthma-related hospitalization within the past 12 months. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (e.g., greater than 100–200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) or ii) One medium dosed combination ICS/LABA product (e.g., Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/ formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [e.g., Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)]. |

| | |
|---|---|
| **Age Restrictions** | 6 years of age or older |
| **Prescriber Restrictions** | Asthma (Initial/Reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. EGPA (initial): Prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Eosinophilic granulomatosis with polyangiitis (EGPA) (Initial): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (ie, corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (eg, prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. Asthma (Reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. EGPA (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# FINTEPLA

## Products Affected

- Fintepla

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of seizures associated with Dravet syndrome and Lennox-Gastaut syndrome. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# FIRMAGON

## Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of advanced or metastatic prostate cancer |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# FLUCYTOSINE

## Products Affected

- Flucytosine CAPS 250MG, 500MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# FOTIVDA

## Products Affected

- Fotivda

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC). Patient has tried at least 2 prior systemic therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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** | Pt has a dx of metastatic colorectal cancer. Pt has been previously treated with both of the following: a) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (eg. FOLFOX, FOLFIRI, FOLFOXIRI) and b) an anti-VEGF therapy( eg. Avastin [bevacizumab], Zaltrap [ziv-afibercept]). One of the following: A) Patient has RAS mutant tumors, OR B) Both of the following: a) Patient has RAS wild-type tumors, AND b) Patient has been previously treated with both of the following: 1) An anti-EGFR biological therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), and 2) One of the following: i) Lonsurf [trifluridine/tipiracil] or ii) Stivarga [regorafenib]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# GATTEX

## Products Affected

- Gattex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | SBS (Init): 6 months. SBS (Reauth): 12 months. |
| **Other Criteria** | SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# GAVRETO

**Products Affected**

- Gavreto

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic RET fusion-positive non-small cell lung cancer (NSCLC). Patient has a diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer. Patient has a diagnosis of advanced or metastatic RET fusion positive thyroid cancer and is radioactive iodine-refractory (if radioactive iodine is appropriate). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# GILENYA

## Products Affected

- Fingolimod Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS. |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | MS (initial, reauth): Prescribed by or in consultation with a neurologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# GILOTRIF

## Products Affected

- Gilotrif

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of previously untreated metastatic non-small cell lung cancer (NSCLC) with tumors expressing non-resistant epidermal growth factor receptor mutations. OR Patient has a diagnosis of metastatic squamous NSCLC and has been previously treated with platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# GLP1 (PREFERRED)

## Products Affected

- Bydureon Bcise
- Liraglutide INJ 6MG/ML
- Mounjaro
- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML
- Ozempic TABS
- Rybelsus TABS 14MG, 3MG, 7MG
- Trulicity

| 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): One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus, submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus, b) submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by one of the following laboratory values: A1c greater than or equal to 6.5%, fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# GOMEKLI

## Products Affected

- Gomekli

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of neurofibromatosis type 1 (NF1) AND has symptomatic plexiform neurofibromas not amenable to complete resection AND will be used as monotherapy. |
| **Age Restrictions** | 2 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# GROWTH HORMONE

**Products Affected**

- Omnitrope

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment. |
| **Required Medical Information** | For CRI: patient is not post-kidney transplant. For TS: diagnosis confirmed by karyotyping. For PWS: diagnosis confirmed by genetic testing. For pediatric GHD, CRI, SHOXD, and NS, patient must meet one of the following: 1) height more than 3 SDS below mean for age and gender 2) Height more than 2 SDS below mean with growth velocity more than 1 SDS below mean, or 3) Growth velocity over 1 year 2 SDS below mean. For adult GHD: must meet one of the following: 1) Failed 2 standard GH stimulation tests 2) Panhypopituitarism or 3 or more pituitary hormone deficiencies 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage 4) Low pre-treatment IGF-1 and failed 1 stimulation test prior to starting treatment |
| **Age Restrictions** | For SGA: patient is more than 2 years old. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal of pediatric indications: final adult height has not been reached. For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not applicable to patients with panhypopituitarism) |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# HARVONI

## Products Affected

- Harvoni

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 or 24 weeks. 8 weeks per prescriber discretion |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# HERNEXEOS

## Products Affected

- Hernexeos

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a dx of unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC). AND tumors have HER2 (ERBB2) tyrosine kinase domain activating mutations, as detected by an FDA-approved test. AND patient has received prior systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# HETLIOZ

## Products Affected

- Tasimelteon

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of non-24-hour sleep-wake disorder and meets the following: patient is totally blind in both eyes and unable to perceive light, for renewals: patient must experience an increase in total nighttime sleep or decreased daytime nap duration. Patient has a diagnosis of Smith-Magenis Syndrome (SMS) and has nighttime sleep disturbance. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Non-24, SMS (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# HRM - ANTIDIABETICS

## Products Affected

- Glyburide TABS 1.25MG, 2.5MG, 5MG
- Glyburide Micronized
- Glyburide/metformin Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient tried and failed to at least one of the following: glipizide, glipizide/metformin, or has contraindications to all alternatives. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Patient will be monitored for hypoglycemia. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# HRM - DIGOXIN

## Products Affected

- Digoxin TABS 250MCG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has tried a lower dose (less than or equal to 0.125mg daily) or has contraindications to a lower dose. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | The patient has been counseled on and does not have signs and symptoms of toxicity. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# HRM - MUSCLE RELAXANTS

## Products Affected

- Chlorzoxazone TABS 500MG
- Cyclobenzaprine Hydrochloride TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The prescriber must attest that the medication benefits outweigh the potential risks. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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 INJ 0

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |

| | |
|---|---|
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist. |
| **Coverage Duration** | UC (Initial): 12 wks,(reauth): Plan Year. All other indications (initial): 6 mo, (reauth): Plan Year |

| | |
|---|---|
| **Other Criteria** | Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or improvement in signs and symptoms of the disease (may include reduction in stool frequency/bloody stools, improvement abdominal pain, or endoscopic response) by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# HYRNUO

## Products Affected

- Hyrnuo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a dx of locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) AND tumors have HER2 (ERBB2) tyrosine kinase domain (TKD) activating mutations, as detected by an FDA-approved test AND pt has received a prior systemic therapy |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IBRANCE

## Products Affected

- Ibrance

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer. Ibrance will be used with an aromatase inhibitor as initial endocrine based therapy OR will be used with fulvestrant in patients with disease progression following endocrine therapy. Patient has a diagnosis of endocrine-resistant, PIK3CA-mutated, HR-positive, HER2-negative, locally advanced or metastatic breast cancer, as detected by an FDA-approved test AND this is following recurrence on or after completing adjuvant endocrine therapy AND this will be used in combination with inavolisib and fulvestrant. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# IBTROZI

## Products Affected

- Ibtrozi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: 1) Locally advanced or 2) Metastatic. Presence of ROS1 rearrangement-positive tumor as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Approve for continuation of prior therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ICATIBANT

## Products Affected

- Icatibant Acetate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of hereditary angioedema. Icatibant will be used for acute attacks of angioedema. Patient has been advised to seek immediate medical attention in addition to treatment with icatibant. Patient has been counseled to use no more than 3 doses in a 24 hour period. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ICLUSIG

## Products Affected

- Iclusig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Patient must not have newly diagnosed chronic phase CML. |
| **Required Medical Information** | Patient has a diagnosis of chronic phase (CP) chronic myeloid leukemia (CML) and has a resistance or intolerance to at least two prior kinase inhibitors. OR Pt has dx of accelerated phase (AP) or blast phase (BP) CML for whom no other kinase inhibitors are indicated. OR Pt has a dx of T315I-positive CML (chronic phase, accelerated phase, or blast phase).OR Pt has a dx of newly diagnosed Ph+ ALL and will be used in combination with chemotherapy. OR pt has a dx of Ph+ ALL for whom no other kinase inhibitors are indicated OR T315I-positive Ph+ ALL AND this will be used as monotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IDHIFA

## Products Affected

- Idhifa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has an isocitrate dehydrogenase-2 (IDH2) mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# IMATINIB

**Products Affected**

- Imatinib Mesylate TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, D) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, G) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL. |
| **Age Restrictions** | 18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# IMBRUVICA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of mantle cell lymphoma (MCL) and patient has received at least one prior therapy. Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL). Diagnosis of CLL/SLL with 17p deletion. Diagnosis of Waldenstrom's macroglobulinemia (WM). Diagnosis of marginal zone lymphoma in patients that have received at least one prior anti-CD20-based therapy such as rituximab. Diagnosis of chronic graft-versus-host disease (cGVHD) after failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate). |
| **Age Restrictions** | (cGVHD): Patient is 1 year of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IMKELDI

## Products Affected

- Imkeldi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) CML. Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Ph+/BCR ABL+ ALL. Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD): Diagnosis of MDS/MPD. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: a) HES or b) CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST. All indications: Patient is unable to swallow generic imatinib tablet due to one of the following: a) Age, b) Physical impairment (e.g., difficulties with motor or oral coordination), c) Dysphagia, or d) Patient is using a feeding tube or nasal gastric tube. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# INCRELEX

## Products Affected

- Increlex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of growth failure in pediatric patients ≥2 years of age with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# INGREZZA

**Products Affected**

- Ingrezza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Concomitant monoamine oxidase inhibitor (MAOI) or tetrabenazine. |
| **Required Medical Information** | Tardive Dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Or patient has a diagnosis of chorea associated with Huntington disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, patient must have improvement in symptoms. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# INLURIYO

## Products Affected

- Inluriyo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a diagnosis of advanced or metastatic breast cancer AND tumor is ER-positive, HER2-negative, ESR1-mutated AND patient has had disease progression following at least one line of endocrine therapy |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# INLYTA

## Products Affected

- Inlyta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma (RCC). Patient has failed one prior systemic therapy, OR patient will use in combination with avelumab or pembrolizumab for first line treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# INQOVI

## Products Affected

- Inqovi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of Myelodysplastic syndrome (MDS). Patient has one of the following French- American-British subtypes: refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, or chronic myelomonocytic leukemia (CMML). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# INREBIC

## Products Affected

- Inrebic

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of intermediate-2 or high risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). Thiamine level was assessed prior to starting treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# INVEGA HAFYERA

## Products Affected

- Invega Hafyera

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with either once-a-month paliperidone palmitate extended-release injectable suspension (Invega Sustenna) for at least 4 months or an every-three-month paliperidone palmitate extended-release injectable suspension (Invega Trinza) for at least one 3 month cycle. Invega Hafyera will only be given once every 6 months. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# INVEGA TRINZA

## Products Affected

- Invega Trinza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with Invega Sustenna for at least 4 months. Invega Trinza will only be given once every 3 months. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IRESSA

## Products Affected

- Gefitinib

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has metastatic non-small cell lung cancer. The tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Patient is using gefitinib first line. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ITOVEBI

## Products Affected

- Itovebi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dx of endocrine-resistant, HR-positive, HER2-negative breast cancer AND it is locally advanced or metastatic AND has one or more PICK3CA mutations as detected by an FDA-approved test AND there is recurrence on or after completing adjuvant endocrine therapy AND will be used in combination with palbociclib and fulvestrant. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IVERMECTIN

## Products Affected

- Ivermectin TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Using for treatment of COVID-19 infection. |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# IVIG

## Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML
- Gammagard Liquid INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 30GM/300ML, 5GM/50ML
- Gammagard Liquid Erc
- Gammaked INJ 10GM/100ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 20GM/400ML, 5GM/100ML
- Gamunex-c INJ 10GM/100ML, 2.5GM/25ML, 20GM/200ML, 40GM/400ML, 5GM/50ML
- Privigen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | History of hypersensitivity to immune globulin or any component of the preparation. |
| **Required Medical Information** | For a diagnosis of ITP: patient must have a trial of corticosteroids unless platelet count is less than 20,000 cells/mm3 and bleeding has occurred. For a diagnosis of hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia: IgG level is less than 500 mg/dL or patient has a history of infection. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# IWILFIN

## Products Affected

- Iwilfin

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient is at risk of relapse of high-risk neuroblastoma in adult and pediatric patients AND have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# JAKAFI

## Products Affected

- Jakafi
- Jakafi Xr

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis). OR Patient has a diagnosis of polycythemia vera and has had an inadequate response to or was intolerant of hydroxyurea. OR Patient has a diagnosis of acute graft-versus-host disease (GVHD) and has failed steroids. OR Patient has a diagnosis of chronic graft-versus-host disease and failed one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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** | Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior therapies for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Patient has received treatment for CLL/SLL with both of the following therapies: a) BTK inhibitor therapy [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib).], and b) B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# JYNARQUE

## Products Affected

- Jynarque TABS
- Tolvaptan TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Autosomal dominant polycystic kidney disease (ADPKD) (initial): Diagnosis of rapidly progressing ADPKD. One of the following: 1) Both of the following: Patient has received Jynarque for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received Jynarque for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months. Patient does not have a history of significant liver impairment or injury, not including uncomplicated polycystic liver disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a nephrologist |
| **Coverage Duration** | Plan Year |

| | |
|---|---|
| **Other Criteria** | ADPKD (reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient does not have signs or symptoms consistent with hepatic injury or 2) Patient has uncomplicated polycystic liver disease. One of the following: 1) Both of the following: Patient has received Jynarque for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received Jynarque for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# KALYDECO

## Products Affected

- Kalydeco

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Statement from physician or lab results showing patient has cystic fibrosis with a CFTR gene mutation responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. Patient is not homozygous for the F508del mutation in the CFTR gene. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | CF (Reauth): Patient demonstrates positive clinical response (i.e. improvement in lung function [percent predicted forced expiratory volume in one second (PPFEV1)], decreased number of pulmonary exacerbations) while on therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# KERENDIA

## Products Affected

- Kerendia

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Chronic kidney disease (CKD) associated with type 2 diabetes (T2D) (Initial): Diagnosis of CKD associated with T2D. Patient has a urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g. Patient has an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2. Patient has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. One of the following: 1) Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following: a) generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. Heart failure (HF) with Left Ventricular Ejection Fraction (LVEF) greater than or equal to 40% (Initial): Diagnosis of HF. Patient has LVEF greater than or equal to 40%. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. Patient has an eGFR greater than or equal to 25 mL/min/1.73 m2. Patient has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. Both of the following: 1) Patient is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment, AND 2) Patient is not receiving drug in combination with spironolactone or eplerenone. One of the following: 1) Patient is receiving drug in combination with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor. |
| **Age Restrictions** | N/A |

| | |
|---|---|
| **Prescriber Restrictions** | HF with LVEF greater than or equal to 40% (Initial): Prescribed by or in consultation with a cardiologist. |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | CKD associated with T2D (Reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB, OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. HF with LVEF greater than or equal to 40% (Reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on an SGLT2 inhibitor, OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID AND dx of NOMID has been confirmed by one of the following: 1) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3) gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation OR 2) Both of the following: a) two of the following clinical symptoms: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia), chronic aseptic meningitis, or skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing) AND b) elevated acute phase reactants (eg, erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA]). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician. |
| **Coverage Duration** | RA, NOMID (initial): 6 months, (reauth): Plan Year DIRA: Plan Year |

| | |
|---|---|
| **Other Criteria** | RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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** | N/A |
| **Required Medical Information** | Patient has a diagnosis of hormone receptor positive, human epidermal growth factor receptor 2 negative advanced or metastatic breast cancer and will be used with either an aromatase inhibitor as initial endocrine-based therapy OR fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy. Concomitant use with fulvestrant does not apply to Kisqali Femara Co-Pack requests. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# KOMZIFTI

## Products Affected

- Komzifti

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a dx of relapsed or refractory acute myeloid leukemia (AML) AND has a  a susceptible nucleophosmin 1 (NPM1) mutation AND has no satisfactory alternative treatment options |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# KORLYM

## Products Affected

- Mifepristone TABS 300MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus) |
| **Required Medical Information** | Patient has a diagnosis of endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance. Patient has failed surgery or is not a candidate for surgery. Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribing physician must be an endocrinologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# KOSELUGO

## Products Affected

- Koselugo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of neurofibromatosis type 1 and has symptomatic, inoperable plexiform neurofibromas. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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 one of the following: locally advanced or metastatic. Disease is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Colorectal Cancer (CRC): Diagnosis of CRC. Disease is one of the following: locally advanced or metastatic. Tumor is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA) -approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Erbitux (cetuximab). Patient has received prior treatment with ALL of the following: a) fluoropyrimidine-based chemotherapy, b) oxaliplatin-based chemotherapy, and c) irinotecan-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# KUVAN

## Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | PKU (Init): 2 months (Reauth): Plan Year |
| **Other Criteria** | PKU (reauth): Patient demonstrates positive clinical response to therapy. Patient will continue to have blood Phe levels measured periodically during therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# LAZCLUZE

## Products Affected

- Lazcluze

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced or metastatic non-small lung cancer (NSCLC) with EGFR exon 19 deletions or exon 21 L858R substitution mutations as detected by an PDA-approved test AND this is first-line treatment AND being used in combination with Rybrevant |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) and has failed one prior anti-angiogenic therapy and will be used with everolimus or will be used first-line in combination with pembrolizumab, OR patient has a diagnosis of unresectable hepatocellular carcinoma (HCC) OR patient has a diagnosis of advanced endometrial carcinoma and will be used with pembrolizumab and does not have microsatellite instability-high or mismatch repair deficient and has had disease progression following prior systemic therapy. Lenvima will be used in combination with everolimus when used for RCC. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# LIDODERM

## Products Affected

- Lidocaine PTCH 5%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Diabetic neuropathy, cancer-related neuropathic pain. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has a diagnosis of post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathic pain. The patch will only be applied to intact skin |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# LIFYORLI

## Products Affected

- Lifyorli

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Relacorilant will be used in combination with nab-paclitaxel for the treatment of adults with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer who have received one to three prior systemic treatment regimens, at least one of which included bevacizumab. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# LONSURF

## Products Affected

- Lonsurf

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND One of the following: Used as a single agent or Used in combination with bevacizumab AND Patient has been previously treated with both of the following: A) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND B) anti-VEGF therapy (e.g., Avastin [bevacizumab]) AND One of the following: A) patient has RAS wild-type tumors and patient has been previously treated with one anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]) OR Patient has RAS mutant tumors. Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Patient has been previously treated with two of the following: fluropyrimidine-based chemotherapy (e.g. fluorouracil), Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# LOQTORZI

## Products Affected

- Loqtorzi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | Some FDA-approved Indications Only. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dx of metastatic or with recurrent, locally advanced nasopharyngeal carcinoma (NPC) in adults AND used as first-line treatment AND in combination with cisplatin and gemcitabine. Treatment (as a single agent) of recurrent unresectable or metastatic NPC in adults with disease progression on or after a platinum-containing chemotherapy |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# LORBRENA

## Products Affected

- Lorbrena

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of anaplastic lymphoma kinase (ALK) positive metastatic non-small cell lung cancer (NSCLC). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# LUMAKRAS

## Products Affected

- Lumakras

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) with a KRAS G12C mutation and has received at least one prior systemic therapy. Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior therapy with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy. Used in combination with Vectibix (panitumumab). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# LYNPARZA

**Products Affected**

- Lynparza TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dx of one of the following: recurrent ovarian cancer (epithelial, fallopian tube, or primary peritoneal) after platinum-based chemotherapy OR Patient has a diagnosis 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. OR Patient has a diagnosis of metastatic HER-2 negative breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. OR Patient has a diagnosis of HER2-negative high risk early breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with neoadjuvant or adjuvant chemotherapy. OR Patient has a diagnosis of patient has metastatic pancreatic adenocarcinoma with deleterious or suspected deleterious germline BRCA mutation who had at least 16 weeks of a first-line platinum-based chemotherapy regimen without disease progression. OR Patient has a diagnosis of advanced epithelial ovarian, fallopian tube or primary peritoneal cancer after a complete or partial response to first-line platinum-based chemotherapy, olaparib will be used in combination with bevacizumab, cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation, genomic instability. OR Patient has a diagnosis of deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer and disease has progressed following prior treatment with enzalutamide or abiraterone. OR Patient has a diagnosis of deleterious or suspected deleterious BRCA-mutated metastatic castration-resistant prostate cancer (mCRPC) AND will be used in combination with abiraterone and prednisone or prednisolone. |

| | |
|---|---|
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# LYTGOBI

## Products Affected

- Lytgobi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma. And disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. And patient has been previously treated. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# MAVYRET

## Products Affected

- Mavyret

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Patient does not have moderate to severe hepatic impairment (Child-Pugh B or C). |
| **Required Medical Information** | Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 8, 12, or 16 weeks |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# MAYZENT

## Products Affected

- Mayzent
- Mayzent Starter Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS. |
| **Required Medical Information** | MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). Patient has been tested for CYP2C9 variants. If the patients has CYP2C9 1/3 or 2/3 the patient will be maintained on 1mg daily. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | MS (initial, reauth): 12 months |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# MEKINIST

## Products Affected

- Mekinist

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has unresectable or metastatic melanoma with BRAF V600E or V600K mutations and Mekinist will be used as a single agent or with dabrafenib (Tafinlar) and patient has not received prior BRAF-inhibitor therapy (Zelboraf, Tafinlar), OR patient has melanoma with BRAF V600E or V600K mutations and involvement of lymph nodes and Mekinist will be used as adjuvant treatment with dabrafenib after complete resection and has not received prior BRAF-inhibitor therapy, OR patient has a diagnosis of BRAF V600E mutation positive metastatic non-small cell lung cancer and will use in combination with dabrafenib, OR patient has a diagnosis of BRAF V600E mutation-positive locally advanced or metastatic anaplastic thyroid cancer and will be used in combination with dabrafenib. OR patient has a diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation and patient has progressed following prior treatment and has no satisfactory alternative treatment options and will be used in combination with dabrafenib. OR patient has a diagnosis of  low grade glioma with a BRAF V600E mutation AND will be used in combination with dabrafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# MEKTOVI

## Products Affected

- Mektovi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Binimetinib (Mektovi) will be used in combination with encorafenib (Braftovi). Patient was not previously treated with a BRAF inhibitor or MEK inhibitor. OR Pt has a dx of metastatic non-small lung cancer (NSCLC) AND has a BRAF V600E mutation as detected by an FDA-approved test AND will be used in combination with encorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# METFORMIN IR

## Products Affected

- Metformin Hydrochloride TABS 750MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Initial: One of the following: a) History of greater than or equal to 12 week trial of another metformin immediate-release strength (e.g., 500mg, 850mg, 1000mg) OR b) Documented history of intolerance to another metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# MIGLUSTAT

## Products Affected

- Miglustat
- Yargesa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of mild to moderate type 1 Gaucher disease. Enzyme replacement therapy is not a therapeutic option due to allergy, hypersensitivity, or poor venous access. Miglustat will be used as monotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# MODEYSO

## Products Affected

- Modeyso

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a dx of diffuse midline glioma AND it is harboring an H3 K27M mutation AND it is progressive disease following prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# MS INTERFERONS (PREFERRED)

## Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NERLYNX

## Products Affected

- Nerlynx

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of early stage HER2-overexpressed breast cancer and has been on trastuzumab based therapy OR patient has a diagnosis of advanced or metastatic HER2-positive breast cancer and has received 2 or more prior anti-HER2 based regimens and will be used in combination with capecitabine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# NEXAVAR

## 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** | Patient has a diagnosis of one of the following: unresectable hepatocellular carcinoma, advanced renal cell carcinoma, or locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NEXLETOL

## Products Affected

- Nexletol

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Heterozygous familial hypercholesterolemia (HeFH), primary hyperlipidemia, established cardiovascular disease (CVD), or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) HeFH, B) Primary hyperlipidemia, C) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR D) At high risk for a CVD event but without established CVD (e.g., diabetes mellitus [type 1 or type 2] in females over 65 years of age or males over 60 years of age). One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initial: 6 months. Reauth: Plan Year |
| **Other Criteria** | Reauth: Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) or pt has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe). |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NEXLIZET

## Products Affected

- Nexlizet

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Heterozygous familial hypercholesterolemia (HeFH), primary hyperlipidemia, established cardiovascular disease (CVD), or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) HeFH, B) Primary hyperlipidemia, C) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR D) At high risk for a CVD event but without established CVD (e.g., diabetes mellitus [type 1 or type 2] in females over 65 years of age or males over 60 years of age). One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 2) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initial: 6 months. Reauth: Plan Year |

| | |
|---|---|
| **Other Criteria** | Reauth: Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Patient continues to receive other lipid-lowering tx (eg statins, ezetimibe) or patient has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NINLARO

## Products Affected

- Ninlaro

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of multiple myeloma. Ixazomib will be used in combination with lenalidomide and dexamethasone. Patient has received at least one prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# NORTHERA

## Products Affected

- Droxidopa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (due to Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and nondiabetic autonomic neuropathy. Patient must also have tried midodrine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a cardiologist or a neurologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# NUBEQA

## Products Affected

- Nubeqa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has non-metastatic castration-resistant prostate cancer (nmCRPC). OR  Patient has a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) and will be using with docetaxel or as a single agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NUCALA

## Products Affected

- Nucala

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |

| | |
|---|---|
| **Required Medical Information** | Asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by one of the following: baseline(pre-tx) peripheral blood eosinophil level is greater than or equal to 150cells/ml or peripheral blood eosinophil levels were greater than or equal to 300cells/ml within the past 12 mo. Patient has had two or more asthma exacerbations requiring systemic corticosteroids(eg, prednisone) within the past 12 mo or Patient has had a prior asthma-related hospitalization within the past 12 mo. One of the following: 1)Both of the following: a)Patient is 6 years of age or older but less than 12 years of age b)Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i)Medium-dose inhaled corticosteroid[ICS](eg, greater than 100–200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]) or ii)One medium dosed combination ICS/LABA product (eg, Wixela Inhub[fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a)Both of the following: i)High-dose ICS(eg, greater than 500 mcg fluticasone propionate equivalent/day) and ii)additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]), OR b)One maximally-dosed combination ICS/LABA product(eg, Wixela Inhub[fluticasone propionate 500mcg/salmeterol 50mcg], budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone 200mcg/vilanterol 25mcg]) |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Asthma (init, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist. |

| | |
|---|---|
| **Coverage Duration** | Plan year |
| **Other Criteria** | Hypereosinophilic Syndrome (HES) (init): Diagnosis of HES. Patient has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is FIP1L1-PDGFRA-negative. Patient has uncontrolled HES defined as both of the following: a) History of 2 or more flares within the past 12 months AND b) Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication, or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). Asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# NUEDEXTA

## Products Affected

- Nuedexta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. Patient does not have any of the following contraindications: a) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | PBA (initial): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | PBA (reauth): Patient demonstrates clinical benefit from ongoing therapy as demonstrated by a decrease in inappropriate laughing or crying episodes. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# NUPLAZID

## Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of Parkinson's disease and is experiencing at least one of the following: hallucinations, delusions. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ODOMZO

## Products Affected

- Odomzo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced basal cell carcinoma (BCC). BCC has either recurred following surgery or radiation therapy or patient was not a candidate for surgery or radiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# OFEV

## Products Affected

- Ofev

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD as documented by all of the following: a) exclusion of other known causes of ILD (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on HRCT revealing SSc-ILD or probable SSc-ILD, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype (initial): 1) diagnosis of chronic fibrosing interstitial lung disease, AND 2) patient has a high-resolution computed tomography (HRCT) showing at least 10% of lung volume with fibrotic features, AND 3) disease has a progressive phenotype as observed by one of the following: decline of forced vital capacity (FVC), worsening of respiratory symptoms, or increased extent of fibrosis seen on imaging. |
| **Age Restrictions** | N/A |

| | |
|---|---|
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist or rheumatologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage and Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# OGSIVEO

## Products Affected

- Ogsiveo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Dx of progressing desmoid tumors in adults who require systemic treatment |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# OJEMDA

## Products Affected

- Ojemda

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | Treatment 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** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ONUREG

## Products Affected

- Onureg

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of acute myeloid leukemia and achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy and patient is not able to complete intensive curative therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# OPIPZA

## Products Affected

- Opipza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a dx of irritability associated with autistic disorder. OR Pt has a dx of Tourette's disorder. OR pt has a dx of schizophrenia AND has tried and failed, has intolerance, or contraindication to at least TWO generic atypical antipsychotics. OR pt has a dx of major depressive disorder (MDD) AND this will be used as adjunctive treatment AND pt has tried and failed, has intolerance, or contraindication to at least TWO generic atypical antipsychotics. |
| **Age Restrictions** | Schizophrenia: 13 years and older, MDD: 18 years and older, Irritability with autistic disorder or Tourette's: 6 years and older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ORENCIA IV

**Products Affected**

- Orencia INJ 250MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Acute graft versus host disease (aGVHD): Used for prophylaxis of aGVHD. Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT. Used in combination with both of the following: calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate. |
| **Age Restrictions** | aGVHD: Patient is 2 years of age or older |
| **Prescriber Restrictions** | RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ORENCIA SC

## 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) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ORGOVYX

## Products Affected

- Orgovyx

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced prostate cancer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ORKAMBI

## Products Affected

- Orkambi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed. |
| **Age Restrictions** | 1 year of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | Diagnosis of advanced or metastatic breast cancer in postmenopausal women or adult men. And disease is ER-positive and HER-2 negative. Patient has the presence of ESR1 mutation as detected by an approved test. And 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** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# OSENVELT

**Products Affected**

- Osenvelt

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Skeletal prevention in Multiple Myeloma (MM)/Bone Metastasis from Solid Tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (e.g., breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. One of the following: 1) One of the following: a) tumor is unresectable or b) surgical resection is likely to result in severe morbidity, OR 2) Approve for continuation of prior therapy. Hypercalcemia of malignancy (HCM): Diagnosis of hypercalcemia of malignancy. Trial and failure, contraindication, or intolerance to one bisphosphonate therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | MM/BMST, GCTB: 12 months, HCM: Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Diagnosis of plaque psoriasis AND Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers). |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# PEGASYS

## Products Affected

- Pegasys

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of adults with hepatitis B e antigen (HBeAg)-positive and HBeAg-negative chronic hepatitis B virus (HBV) infection who have compensated liver disease and evidence of viral replication and liver inflammation OR treatment of pediatric patients =3 years of age with HBeAg-positive chronic HBV infection who are non-cirrhotic and have evidence of viral replication and elevations of serum alanine aminotransferase OR dx of advanced essential thrombocythemia OR dx of advanced polycythemia vera. Or pt has a dx of chronic hepatitis C infection AND has compensated liver disease AND has one of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# PEMAZYRE

**Products Affected**

- Pemazyre

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement and patient has been previously treated. Patient has a diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with fibroblast growth factor receptor 1 (FGFR1) rearrangement. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# 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** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced or metastatic breast cancer. Patient has HR positive and HER2 negative markers. Patient has PIK3CA mutated disease. Progressed on or after endocrine based regimen. Piqray will be used with fulvestrant. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# POMALYST

## Products Affected

- Pomalidomide

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy 3) Will be used in combination with dexamethasone. For Kaposi sarcoma (KS): patient has AIDS-related KS after failure of highly active antiretroviral therapy or patient is HIV-negative. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# PROMACTA

## Products Affected

- Eltrombopag Olamine

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS). |
| **Required Medical Information** | Patient has a diagnosis of one of the following immune (idiopathic) thrombocytopenic purpura (ITP): relapsed/refractory immune ITP, persistent ITP, or chronic ITP and meets both of the following: baseline platelet count less than 50,000/mcL, had an insufficient response to either corticosteroids, immunoglobulins, or splenectomy. Patient has a diagnosis of severe aplastic anemia with a platelet count less than 30,000/mcL. Patient has a diagnosis of thrombocytopenia in a patient with chronic hepatitis C. Other Criteria: ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hepatitis C (reauth): One of the following: 1) For patients that started treatment with eltrombopag prior to initiation of treatment with interferon, eltrombopag will be approved when both of the following are met: a) Currently on antiviral interferon therapy for treatment of chronic hepatitis C and b) Documentation that the patient reached a threshold platelet count that allows initiation of antiviral interferon therapy with eltrombopag treatment by week 9, OR 2) For patients that started treatment with eltrombopag while on concomitant treatment with interferon, eltrombopag will be approved based on the following: Currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |

| | |
|---|---|
| **Coverage Duration** | Plan year |
| **Other Criteria** | ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hepatitis C (reauth): One of the following: 1) For patients that started treatment with eltrombopag prior to initiation of treatment with interferon, eltrombopag will be approved when both of the following are met: a) Currently on antiviral interferon therapy for treatment of chronic hepatitis C and b) Documentation that the patient reached a threshold platelet count that allows initiation of antiviral interferon therapy with eltrombopag treatment by week 9, OR 2) For patients that started treatment with eltrombopag while on concomitant treatment with interferon, eltrombopag will be approved based on the following: Currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# PROVIGIL

## Products Affected

- Modafinil TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder. |
| **Age Restrictions** | 17 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# QINLOCK

## Products Affected

- Qinlock

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced gastrointestinal stromal tumor (GIST). Patient has received 3 or more prior kinase inhibitors, including imatinib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# QUININE

## Products Affected

- Quinine Sulfate CAPS 324MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Babesiosis, uncomplicated Plasmodium vivax malaria. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of uncomplicated Plasmodium falciparum malaria, uncomplicated Plasmodium vivax malaria, or babesiosis. Patient is not prescribed quinine for the treatment or prevention of leg cramps. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# QULIPTA

## Products Affected

- Qulipta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Episodic Migraine (EM) (initial): Both of the following: 1) Diagnosis of EM and 2) Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. |
| **Age Restrictions** | EM, CM (initial): 18 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | EM, CM (init): 6mo. EM, CM (reauth): Plan Year |
| **Other Criteria** | EM, CM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REGRANEX

## Products Affected

- Regranex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has diabetes. Patient has neuropathic ulcers on the lower extremity that extend into the subcutaneous tissue or beyond and have an adequate blood supply (i.e. is not an ischemic ulcer). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 20 weeks |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# RELISTOR

## Products Affected

- Relistor

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Patient with known or suspected mechanical GI obstruction and at increased risk of recurrent obstruction. |
| **Required Medical Information** | Patient has a diagnosis of opioid induced constipation with either chronic non cancer pain or advanced illness or pain caused by cancer who are receiving palliative care, when response to laxative therapy has not been sufficient. Patient has had an inadequate response to lubiprostone or Movantik. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# REPATHA

## Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH or HoFH), primary hyperlipidemia and requires additional lowering of LDL cholesterol AND patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. OR patient has a diagnosis or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol and patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin) or patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. |
| **Age Restrictions** | Patient is 10 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# RESPIRATORY PDE-5 INHIBITOR

## Products Affected

- Alyq
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Receiving nitrate therapy (includes intermittent use) |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has (WHO Group I) PAH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# RETEVMO

## Products Affected

- Retevmo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer with RET fusion-positive disease. OR patient has a diagnosis of advanced or metastatic RET-mutant medullary thyroid cancer. OR patient has a diagnosis of advanced or metastatic RET fusion-positive thyroid cancer and is refractory to radioactive iodine (if radioactive iodine is appropriate). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REVCOVI

## Products Affected

- Revcovi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Severe thrombocytopenia (less than 50,000/microL) |
| **Required Medical Information** | Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID)and confirmed by one of the following: a) Deficiency or absence of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus sample b) Increase in either deoxyadenosine triphosphate (dATP) levels or in total deoxyadenosine nucleotides (dAXP) in erythrocytes. c) Decrease in ATP concentration in erythrocytes. d) Molecular genetic confirmation of mutations in both alleles of the ADA1 gene. e) Positive screening by T-cell receptor excision circles (TRECs). Treatment will be used only until definitive therapy with hematopoietic stem cell transplantation (HSCT), or if the patient is not a suitable candidate or has previously failed HSCT. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an immunologist, hematologist/oncologist, or physician who specializes in ADA-SCID or related disorders |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Reauth: Clinically significant improvement or stabilization in clinical signs and symptoms of the disease (Including but not limited to improved or stabilized plasma ADA activity, dAXP levels, total lymphocyte counts, and/or immune function) AND If previously approved as a bridge to definitive therapy with HSCT: Provider attests patient has not yet undergone HSCT OR Prescriber attests patient is still not eligible candidate for HSCT |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REVLIMID

## Products Affected

- Lenalidomide

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone or as maintenance therapy after autologous hematopoietic stem cell transplant. OR Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5 q cytogenetic abnormality with or without additional cytogenetic abnormalities. OR Diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. AND Patient is not using the medication for the treatment of chronic lymphocytic leukemia. OR Patient has a diagnosis of follicular or marginal zone lymphoma that has been previously treated and will be used with a rituximab product. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# REVUFORJ

## Products Affected

- Revuforj

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pt has a dx of relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation |
| **Age Restrictions** | Greater than or equal to 1 year of age |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REZDIFFRA

## Products Affected

- Rezdiffra

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Initial: Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Disease is fibrosis stage F2 or F3 as confirmed by one of the following: 1) Both of the following: A) Serum biomarker [e.g., enhanced liver fibrosis (ELF) test, fibrosis-4 index (FIB-4)], and B) Imaging biomarker [e.g., FibroScan, magnetic resonance imaging-proton density fat fraction (MRI-PDFF)], or 2) One of the following: A) FibroScan aspartate aminotransferase (FAST), B) MRI-aspartate aminotransferase (MAST), C) Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB), or D) Liver biopsy within the past 12 months. Presence of 1 metabolic risk factor that is managed according to standard of care (e.g., Type 2 diabetes, hypertension, obesity). |
| **Age Restrictions** | Age 18 or older |
| **Prescriber Restrictions** | Initial: Prescribed by or in consultation with a gastroenterologist or hepatologist. |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Reauth: Patient demonstrates positive response to therapy. Patient has not progressed to cirrhosis. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REZLIDHIA

## Products Affected

- Rezlidhia

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# REZUROCK

## Products Affected

- Rezurock

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic graft-versus-host disease (chronic GVHD). Patient has had a failure of at least 2 prior lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# RINVOQ

## Products Affected

- Rinvoq
- Rinvoq Lq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Rheumatoid arthritis (RA)(init): Diagnosis (Dx) of moderately to severely active RA. RA,PJIA(init): Minimum (min) duration of a 3-mo(RA)/6-wk(PJIA) trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, (RA only) sulfasalazine. Psoriatic arthritis (PsA)(init): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS)(init): Dx of active AS. Non-radiographic axial spondyloarthritis(NRAS, init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one TNF inhibitors (TNF-I) (eg, certolizumab pegol). AS, NRAS(init): Min duration of a 1-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PJIA, PsA, AS(init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab, etanercept). RA, PJIA, PsA, AS, NRAS(init, reauth): Not used in combo with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine [AZA], cyclosporine [CYC]). Atopic dermatitis(AD)(init): Dx of moderate to severe AD. One of the following: Involvement of at least 10% body surface area (BSA), or SCORing Atopic Dermatitis (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for topical corticosteroids), C/I to one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus, Tacrolimus oint, or Eucrisa. One of the following: 1) TF of a min 12-wk supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to Dupixent), OR 2) Pt has a C/I, or treatment is inadvisable with the following FDA-approved AD therapy: Dupixent. Not used in combo with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC). |

| | |
|---|---|
| **Age Restrictions** | AD (initial): Patient is 12 years of age or older |
| **Prescriber Restrictions** | RA, PJIA, AS, NRAS (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. CD, UC (init): Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | RA, PJIA, PsA, AS, NRAS, CD, UC, AD, giant cell arteritis (init): 6 months, (reauth): Plan Year |

| | |
|---|---|
| **Other Criteria** | Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. Crohn's disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative colitis (UC) (init): Dx of moderately to severely active UC. One of the following: greater than 6 stools/day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab), OR if treatment is inadvisable (ie, CI) with a TNF-I, pt has had a trial of a systemic therapy approved for CD/UC (eg, risankizumab, ustekinumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC). Giant cell arteritis (GCA) (init): Dx of GCA. GCA (reauth): Pt demonstrates positive clinical response to therapy. GCA (init, reauth): Not used in combo with other JAK-I, biologic DMARDs, or potent immunosuppressants (eg, AZA, CYC). RA, PJIA (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (ESR, CRP), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC). CD/UC (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, ESR, CRP]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC). |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ROMVIMZA

## Products Affected

- Romvimza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) AND surgical resection will potentially cause worsening functional limitation or severe morbidity |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ROZLYTREK

## Products Affected

- Rozlytrek

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer with ROS1-positive tumors. OR Patient has solid tumors that meet the following: have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, patient has either progressed following treatment or has no satisfactory alternative therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# RUBRACA

## Products Affected

- Rubraca

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic castration resistant prostate cancer with a deleterious BRCA mutation and has been treated with androgen receptor directed therapy and taxane based chemotherapy. OR rucaparib will be used for the maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# RYDAPT

## Products Affected

- Rydapt

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of new onset acute myeloid leukemia (AML) that is FLT3 mutation positive, aggressive systemic mastocytosis, systemic mastocytosis with associated hematological neoplasm, mast cell leukemia. For patients with AML, midostaurin will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Midostaurin will not be used as a single-agent induction for AML. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SCEMBLIX

## Products Affected

- Scemblix

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP). OR Ph+ CML in CP with the T315I mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SIGNIFOR

## Products Affected

- Signifor

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Cushing's disease (initial): Diagnosis of Cushing’s disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | (For Cushing's disease): Prescribed by or in consultation with an endocrinologist |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SIGNIFOR LAR

## Products Affected

- Signifor Lar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option OR Treatment of Cushing disease in patients for whom pituitary surgery is not an option or has not been curative |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | (For Cushing's disease): Prescribed by or in consultation with an endocrinologist |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Acromegaly (reauth): Patient demonstrates positive clinical response to therapy (e.g., patient’s growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved). Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease). |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SKYRIZI

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# SODIUM OXYBATE

## Products Affected

- Sodium Oxybate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Taking alcohol or sedative hypnotic agents while taking sodium oxybate. |
| **Required Medical Information** | Patient has a diagnosis of narcolepsy with either cataplexy or excessive daytime sleepiness. For patients with a diagnosis of excessive daytime sleepiness, patient has had a previous trial with or a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# SOMATULINE

## Products Affected

- Lanreotide Acetate
- Somatuline Depot

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of either Acromegaly or gastroenteropancreatic neuroendocrine tumors (GEP-NETs), or carcinoid syndrome. For acromegaly, patient has had an inadequate or partial response to surgery and/or radiotherapy or patient was not a candidate for surgery or radiotherapy. For GEP-NETs, tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SOMAVERT

## Products Affected

- Somavert

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# SPRYCEL

## Products Affected

- Dasatinib

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gastrointestinal stromal tumor (GIST). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Newly diagnosed adults with Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive CML with resistance or intolerance to prior therapy including imatinib. Adults with diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy. Pediatric patients with a diagnosis of Philadelphia chromosome-positive CML in chronic phase or newly diagnosed Philadelphia chromosome-positive ALL in combination with chemotherapy. For patients with GIST, patient must have progressed on imatinib or sunitinib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# STELARA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose. |
| **Age Restrictions** | Plaque psoriasis, PsA: Patient is 6 years of age or older. |
| **Prescriber Restrictions** | Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD (Reauth), UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. All indications: Pt trial of or C/I to Wezlana |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# STELARA IV

## Products Affected

- Stelara INJ 130MG/26ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | One time |
| **Other Criteria** | Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg. All indications: Pt T/F or C/I to Wezlana |

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|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# STEQEYMA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. |
| **Age Restrictions** | Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older. |
| **Prescriber Restrictions** | Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. |

| | |
|---|---|
| **Coverage Duration** | All uses (Initial): 6 months. All uses (Reauth): 12 months. |
| **Other Criteria** | PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# STEQEYMA IV

## Products Affected

- Steqeyma INJ 130MG/26ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | One time |
| **Other Criteria** | Wezlana is to be administered as an intravenous induction dose. Wezlana induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg. |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# STIVARGA

## Products Affected

- Stivarga

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of: A) metastatic colorectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan -based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy or B) gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic AND patient has tried and had an inadequate response, contraindication or intolerance to imatinib and sunitinib or C) hepatocellular carcinoma and has been previously treated with sorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# SUTENT

## Products Affected

- Sunitinib Malate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of advanced/metastatic renal cell carcinoma or as an adjuvant treatment after nephrectomy. Diagnosis of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib. Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in a patient with unresectable locally advanced or metastatic disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# SYMLIN

## Products Affected

- Symlinpen 120
- Symlinpen 60

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of type 1 or type 2 diabetes mellitus.<br>Patient is currently receiving optimal mealtime insulin therapy.<br>Patient has had an inadequate treatment response to insulin. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TABRECTA

## Products Affected

- Tabrecta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TAFINLAR

## Products Affected

- Tafinlar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation and will be used in combination with trametinib, OR a diagnosis of unresectable or metastatic melanoma AND will be used as monotherapy in patients with the BRAF V600E mutation OR dabrafenib will be used in combination with trametinib in patients with BRAF V600E or V600K mutations, OR patient has a diagnosis of melanoma with BRAF V600E or V600K mutations with lymph node involvement and will be used in combination with trametinib after complete resection, OR patient has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutations and will be used with trametinib. OR patient has a diagnosis of unresectable or metastatic solid tumors with BRAF V600E mutation and patient has progressed following prior treatment and has no satisfactory alternative treatment options and will be used in combination with trametinib. OR patient has a diagnosis of low grade glioma with a BRAF V600E mutation AND will be used in combination with trametinib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TAGRISSO

**Products Affected**

- Tagrisso

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of non-small cell lung cancer (NSCLC) and meets the following criteria: patient will use osimertinib as adjuvant therapy after tumor resection and tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations, osimertinib will be used first-line in metastatic disease and tumors have EGFR exon 19 deletions or exon 21 L858R mutations, or osimertinib will be used in patients with EGFR T790M mutation-positive metastatic disease and patient has progressed on or after EFGR tyrosine kinase inhibitor therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TALZENNA

## Products Affected

- Talzenna

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced or metastatic breast cancer. Patient has deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated human epidermal growth factor receptor 2 (HER2) negative disease. OR Patient has a diagnosis of homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer AND will be used in combination with enzalutamide. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TARGRETIN

## 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** | For gel: patient has a diagnosis of stage 1A or 1B cutaneous T-cell lymphoma that is refractory or persistent after treatment with other therapies or has not tolerated other therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TASIGNA

## Products Affected

- Nilotinib D-tartrate
- Nilotinib Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval |
| **Required Medical Information** | Patient has a diagnosis of newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase OR Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia in chronic or accelerated phase |
| **Age Restrictions** | Age 1 and older for pediatric indications |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TAZVERIK

## Products Affected

- Tazverik

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic or locally advanced epithelioid sarcoma and is not eligible for complete resection. OR Patient has a diagnosis of relapsed or refractory follicular lymphoma with one of the following: tumors are positive for an EZH2 mutation and patient received at least 2 prior systemic therapies, or patient has no satisfactory alternative treatment options. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TECFIDERA

## Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Patient must have a complete blood count within the past 6 months before initiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | To continue therapy, the patient must demonstrate stabilization or improvement while on dimethyl fumarate. |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TEPMETKO

## Products Affected

- Tepmetko

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TETRABENAZINE

## Products Affected

- Tetrabenazine

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Tardive dyskinesia, Tourette's syndrome. |
| **Exclusion Criteria** | Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. |
| **Required Medical Information** | Diagnosis of chorea associated with Huntington's disease. If treating for tardive dyskinesia, require failure of at least one previous therapy (e.g., amantadine, benzodiazepines, haloperidol, atypical antipsychotics, etc.) or Gilles de la Tourette's syndrome with failure or least one previous therapy (e.g., antipsychotic agents, clonidine). Patients who require doses greater than 50 mg/day will be genotyped for CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, patient must have a lack of disease progression or have improvement in symptoms. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# THALOMID

## Products Affected

- Thalomid

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of: A) multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone B) acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum C) Maintenance therapy for prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence. Thalidomide will not be used as monotherapy for erythema nodosum leprosum treatment if the member has moderate to severe neuritis |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TIBSOVO

## Products Affected

- Tibsovo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. OR Patient has a diagnosis of newly-diagnosed AML with a susceptible IDH1 mutation in a patient that is at least 75 years old or who has comorbidities that preclude the use of intensive induction chemotherapy. OR Patient has a diagnosis of previously treated, locally advanced or metastatic cholangiocarcinoma with an IDH1 mutation. Or patient has a dx of relapsed or refractory myelodysplastic syndromes with a susceptible IDH1 mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TRANSMUCOSAL FENTANYL PRODUCTS

## Products Affected

- Fentanyl Citrate Oral Transmucosal

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has active cancer and TIRF will be used for breakthrough cancer pain. Patient has tried and failed or has contraindications to at least 2 of the following short acting narcotics: oxycodone, morphine sulphate, hydromorphone. Long-Acting opioid is being prescribed The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.). |
| **Age Restrictions** | 16 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TRIKAFTA

## Products Affected

- Trikafta TBPK 100MG; 0; 50MG
- Trikafta THPK

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of cystic fibrosis and 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. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | Dx of locally advanced or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in adults with one or more PIK3CA/AKT1/PTEN-alteration (as detected by an approved test) AND following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy AND used in combination with fulvestrant |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TUKYSA

## Products Affected

- Tukysa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has a diagnosis of advanced unresectable or metastatic breast cancer. Patient has HER2-positive disease and has received one or more prior anti-HER2-based regimen. Tukysa will be used in combination with trastuzumab and capecitabine. OR Patient has a diagnosis of RAS wild-type, HER2-positive unresectable or metastatic colorectal cancer AND will be used in combination with trastuzumab AND the disease has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TURALIO

## Products Affected

- Turalio CAPS 125MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of tenosynovial giant cell tumor (TGCT) and be symptomatic. Patients disease must be associated with severe morbidity or functional limitations and not be amenable to improvement with surgery. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# TYKERB

## Products Affected

- Lapatinib Ditosylate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced or metastatic breast cancer with overexpression of HER2 AND lapatinib will be used with capecitabine AND patient has received prior therapy with an anthracycline, a taxane, and trastuzumab. OR Patient is postmenopausal with a diagnosis of hormone receptor positive metastatic breast cancer with overexpression of HER2 AND lapatinib will be used with letrozole. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# TYMLOS

## Products Affected

- Tymlos

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment of osteoporosis in postmenopausal females who are at high risk for fracture (defined as history of osteoporotic fracture or multiple risk factors for fracture) OR treatment to increase bone density in males who are high risk for fracture (defined as history of osteoporotic fracture or multiple risk factors for fracture). OR may also be used in patients who have failed or are intolerant to other available osteoporosis therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# UBRELVY

## Products Affected

- Ubrelvy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Will not be used for preventive treatment of migraine. Patient has fewer than 15 headache days per month. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# UPTRAVI

## Products Affected

- Uptravi
- Uptravi Titration Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | PAH (Reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# USTEKINUMAB

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn¿s disease. Will be used as a maintenance dose following the intravenous induction dose. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. All indications (initial): Trial of either Steqeyma or Wezlana. |
| **Age Restrictions** | Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older. |
| **Prescriber Restrictions** | Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. |

| | |
|---|---|
| **Coverage Duration** | All uses (Initial): 6 months. All uses (Reauth): 12 months. |
| **Other Criteria** | PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# USTEKINUMAB (IV)

## Products Affected

- Ustekinumab INJ 130MG/26ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | One time |
| **Other Criteria** | Ustekinumab is to be administered as an intravenous induction dose. Ustekinumab induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg. |

| | |
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| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VALCHLOR

## Products Affected

- Valchlor

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Topical treatment of stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy (e.g., topical corticosteroids [e.g., clobetasol, fluocinonide], bexarotene topical gel [Targretin topical gel], etc.) |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VANFLYTA

## Products Affected

- Vanflyta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of acute myeloid leukemia (AML). And patient has a FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)–positive (as detected by an approved test). And will be used in combination with standard cytarabine and anthracycline (e.g., daunorubicin, idarubicin) induction and cytarabine consolidation. And will be used as maintenance monotherapy following consolidation chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VENCLEXTA

## Products Affected

- Venclexta
- Venclexta Starting Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Must not be on a strong CYP3A inhibitor (such as ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, or voriconazole) at Venclexta initiation and during Venclexta ramp-up phase. |
| **Required Medical Information** | Patient has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Patient has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) in adults 75 or older or who have comorbidities that preclude the use of intensive induction chemotherapy AND Venclexta will be used in combination with azacitidine, or decitabine, or low-dose cytarabine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VERQUVO

## Products Affected

- Verquvo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic heart failure (CHF) AND has an ejection fraction less than 45 percent AND has New York Heart Association (NYHA) Class II, III, or IV symptoms. AND one of the following: A) Patient was hospitalized for heart failure within the last 6 months OR B) Patient used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months. AND trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), 2) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), or 3) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)], B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VERZENIO

## Products Affected

- Verzenio

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has advanced or metastatic hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative breast cancer AND patient will use in combination with an aromatase inhibitor as initial treatment in adults OR will be used in combination with fulvestrant in patients that had disease progression following endocrine therapy OR patient has metastatic disease and it will be used as monotherapy for patients that had disease progression following endocrine therapy and prior chemotherapy. Patient has a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence and will be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VIGAFYDE

## Products Affected

- Vigafyde

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of infantile spasms. Trial or intolerance to generic vigabatrin. |
| **Age Restrictions** | Patient is 1 month to 2 years of age. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Approve for continuation of prior therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VITRAKVI

## Products Affected

- Vitrakvi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.). Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.). Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]. Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VIZIMPRO

## Products Affected

- Vizimpro

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations. Vizimpro will be used as a first-line treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | Patient has a diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). Patient has a platelet count below 50 x 10 9/L. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | PLAN YEAR |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VOQUEZNA

## Products Affected

- Voquezna
- Voquezna Dual Pak
- Voquezna Triple Pak

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Helicobacter pylori (H. pylori) (Voquezna Dual Pak, Voquezna Triple Pak): Diagnosis of H. pylori infection. Trial and failure, contraindication, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). H. pylori (Voquezna): Diagnosis of H. pylori infection. One of the following: a) Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection, or b) Used in combination with amoxicillin for the treatment of H. pylori infecion. Trial and failure, contraindication, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). Healing and Relief of Heartburn associated with Erosive Esophagitis (HRH) (Voquezna): Diagnosis of erosive esophagitis. Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, or e) rabeprazole. Maintenance of Healing and Relief of Heartburn associated with Erosive Esophagitis (MHRH) (Voquezna): Used to maintain healing and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, or e) rabeprazole. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |

| | |
|---|---|
| **Coverage Duration** | H. pylori, NERD: 1 mo. HRH: 2 months. MHRH: 6 mos. |
| **Other Criteria** | Relief of Heartburn associated with Non-Erosive Gastroesophageal Reflux Disease (NERD): Diagnosis of non-erosive Gastroesophageal Reflux Disease. Both of the following: a) Patient has history of heartburn for at least 6 months and b) Heartburn symptoms are present for at least 4 days during any consecutive 7-day period. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, or e) rabeprazole. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VORANIGO

## Products Affected

- Voranigo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of grade 2 astrocytoma or oligodendroglioma with a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation AND following surgery, including biopsy, subtotal resection, or gross total resection |
| **Age Restrictions** | 12 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VORICONAZOLE INJECTION

## Products Affected

- Voriconazole INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VOSEVI

## Products Affected

- Vosevi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# VOTRIENT

## Products Affected

- Pazopanib Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma or advanced soft tissue sarcoma. Patients with a diagnosis of soft tissue sarcoma must have received prior chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# VOWST

## Products Affected

- Vowst

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of two or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Dificid (fidaxomicin), 2) Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days). |
| **Age Restrictions** | Patient is 18 years of age or older. |
| **Prescriber Restrictions** | Prescribed by or in consultation with a gastroenterologist or infectious disease specialist. |
| **Coverage Duration** | 14 days |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# WELIREG

## Products Affected

- Welireg

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of von Hippel-Lindau (VHL) disease and requires therapy for associated renal cell carcinoma, central nervous system hemangioblastomas, or pancreatic neuroendocrine tumors (pNET) not requiring immediate surgery. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) following a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI). OR Patient has a diagnosis of locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma (PPGL). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# WEZLANA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar. Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose |
| **Age Restrictions** | Plaque psoriasis, PsA: Patient is 6 years of age or older. |
| **Prescriber Restrictions** | Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | Plan year |

| | |
|---|---|
| **Other Criteria** | Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD (Reauth), UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# WEZLANA IV

## Products Affected

- Wezlana INJ 130MG/26ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, methotrexate, corticosteroid (eg, prednisone). Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), or an aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a gastroenterologist. |
| **Coverage Duration** | One time |
| **Other Criteria** | Wezlana is to be administered as an intravenous induction dose. Wezlana induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg. |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# WINREVAIR

## Products Affected

- Winrevair

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (Initial): Patient has a diagnosis of pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). Patient has WHO functional class II or III symptoms. Patient is currently on at least two therapies indicated for the treatment of PAH from the following different mechanisms of action, unless there is a contraindication or intolerance: a) Endopthelin receptor antagonists (ie, Bosentan, ambrisentan or macitentan) and b) Phosphodiesterase 5 inhibitors (ie, Tadalafil or sildenafil). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist. |
| **Coverage Duration** | PAH: Initial: 6 months. Reauth: Plan Year |
| **Other Criteria** | PAH (Reauth): Patient demonstrates positive clinical response to therapy. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# WYOST

## Products Affected

- Wyost

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Skeletal prevention in Multiple Myeloma (MM)/Bone Metastasis from Solid Tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (e.g., breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. One of the following: 1) One of the following: a) tumor is unresectable or b) surgical resection is likely to result in severe morbidity, OR 2) Approve for continuation of prior therapy. Hypercalcemia of malignancy (HCM): Diagnosis of hypercalcemia of malignancy. Trial and failure, contraindication, or intolerance to one bisphosphonate therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | MM/BMST, GCTB: 12 months. HCM: 2 months. |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# XALKORI

## Products Affected

- Xalkori

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) and the tumor is ROS1- or ALK-positive. Patient is a pediatric patient or a young adult with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive. Patient has a diagnosis of unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT) that is ALK-positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# XELJANZ

## Products Affected

- Xeljanz
- Xeljanz Xr

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Xeljanz tab/Xeljanz XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Enbrel, adlimumab). Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist. |

| | |
|---|---|
| **Coverage Duration** | Plan year |
| **Other Criteria** | Xeljanz: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Enbrel, adalimumab). RA, PsA, AS, PJIA (Initial): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. RA, PsA, AS, PJIA (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine). |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# XERMELO

## Products Affected

- Xermelo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of carcinoid syndrome diarrhea. Patient will also be on a somatostatin analog (SSA) therapy (e.g., octreotide). Patient has had inadequate control on SSA therapy after a trial of at least 3 months. Patient has at least 4 bowel movements per day. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or gastroenterologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# XIFAXAN

## Products Affected

- Xifaxan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | (For Travelers' diarrhea): Should not be used in patients with diarrhea complicated by fever or blood in the stool or diarrhea caused by pathogens other than E. coli |
| **Required Medical Information** | Travelers' diarrhea (TD): Diagnosis of travelers' diarrhea. One of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis (ppx) of hepatic encephalopathy (HE) recurrence (initial): Used for the prophylaxis of hepatic encephalopathy recurrence, AND One of the following: 1) Trial and failure, contraindication or intolerance to lactulose or 2) Add-on treatment to lactulose. Treatment (tx) of HE: Used for the treatment of HE. One of the following: 1) Trial and failure, contraindication, or intolerance to lactulose or 2) Add-on treatment to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide]. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | TD: 14 days. HE (tx): Plan Year. HE (ppx) (init, reauth): Plan Year. IBS-D (init, reauth): 2 weeks. |
| **Other Criteria** | Prophylaxis of HE recurrence (reauth): Patient demonstrates positive clinical response to therapy. IBS-D (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy. |

| | |
|---|---|
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# XOLAIR

## Products Affected

- Xolair

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of moderate or persistent asthma with base inadequate control on either inhaled corticosteroids and long acting beta agonist or inhaled corticosteroids and long acting muscarinic antagonist, a diagnosis of chronic idiopathic urticaria who remained symptomatic after previous trials of H1 antihistamines, or a diagnosis of nasal polyps and will be used as add-on maintenance in patients with an inadequate response to nasal corticosteroids. Or patient has a diagnosis of an IgE-mediated food allergy and Xolair is being used for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. AND this will be used in conjunction with food allergen avoidance. |
| **Age Restrictions** | Asthma age 6 and older, Chronic idiopathic Urticaria Age 12 and older, nasal polyps age 18 and older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# XOSPATA

## Products Affected

- Xospata

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has a FMS-like tyrosine kinase 3 (FLT3) mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# XPOVIO

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory multiple myeloma (RRMM) and meet one of the following criteria: 1) received at least four prior therapies, disease must be refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody, and therapy must be used in combination with dexamethasone or 2) patient has received at least one prior therapy and it will be used in combination with bortezomib and dexamethasone. OR Patient has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including arising from follicular lymphoma and must have tried at least 2 lines of systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# XTANDI

## Products Affected

- Xtandi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of castration-resistant prostate cancer (CRPC) OR metastatic castration-sensitive prostate cancer OR non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For patients with metastatic, castration-resistant prostate cancer in patients who are not currently taking Xtandi, the patient must have had a trial with abiraterone (Zytiga) unless the patient is unable to try abiraterone. |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# YONSA

## Products Affected

- Yonsa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Prostate Cancer: Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Trial and failure or intolerance to Xtandi (enzalutamide). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Approve for continuation of prior therapy |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ZEJULA

**Products Affected**

- Zejula TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. OR Patient has a diagnosis of of deleterious or suspected deleterious germline BRCA-mutated (gBRCAmut) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ZELBORAF

## Products Affected

- Zelboraf

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation OR patient has a diagnosis of Erdheim-Chester Disease (ECD) with BRAF V600E mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ZOLINZA

## Products Affected

- Zolinza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease. Patient has received at least two prior systemic therapies (e.g., bexarotene, romidepsin, etc.). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES require use of a prerequisite Part D drug. |

# ZTALMY

## Products Affected

- Ztalmy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# 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** | Patient has a diagnosis of Postpartum Depression (PPD). Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae. |
| **Age Restrictions** | PPD: Patient is 18 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ZYDELIG

## Products Affected

- Zydelig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# ZYKADIA

## Products Affected

- Zykadia TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer and has anaplastic lymphoma kinase (ALK)-positive disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |
| **Prerequisite Therapy Required** | Criteria DOES NOT require use of a prerequisite Part D drug. |

# PART B VERSUS PART D

## Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 50MG
- 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, 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 270MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 400MG/100ML; 200MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/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
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant
- Arformoterol Tartrate
- Astagraf XL
- Azathioprine TABS 50MG
- Bleomycin Sulfate INJ
- 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
- Clinolipid

- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Doxorubicin Hcl INJ 2MG/ML, 50MG
- Doxorubicin Hydrochloride INJ 10MG
- Dronabinol
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Formoterol Fumarate NEBU
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol Hcl NEBU 0.63MG/3ML
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myhibbin
- Nutrilipid
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- 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
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tacrolimus Er
- Tobramycin NEBU 300MG/5ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML

- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ 1MG/ML

## Details

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

# INDEX

***D***



***E***



***F***

***Q***



***R***



***S***



***T***

***U***



***V***



***W***



***X***



***Y***



***Z***