



people powered health plans



## **2025 PRIOR AUTHORIZATION CRITERIA**

**UCare Classic (HMO-POS)**  
**UCare Complete (HMO-POS)**  
**UCare Essentials Rx (HMO-POS)**  
**UCare Standard (HMO-POS)**  
**UCare Aware (HMO-POS)**  
**EssentiaCare Secure (PPO)**  
**EssentiaCare Grand (PPO)**  
**EssentiaCare Access (PPO)**  
**UCare Medicare Group Plans (HMO-POS)**  
**UCare Advocate Choice (HMO I-SNP)**  
**UCare Advocate Plus (HMO I-SNP)**

UCare requires your provider to get prior authorization for certain drugs. This means that you'll need to get approval from us before you fill your prescriptions. If you don't get approval, UCare may not cover the drug.

**Last updated: 12/01/2025**

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U4511 12/2025

## **Notice of Nondiscrimination**

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

### Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

### Written grievance

#### *Mailing Address*

UCare

Attn: Appeals and Grievances

PO Box 52

Minneapolis, MN 55440-0052

Email: [cag@ucare.org](mailto:cag@ucare.org)

Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телефон: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាកាសវិញ, សវវាដែនូយ៉ាងីកការការណ៍ ដោយមិនគិតិត្សលេកអាចមានសំរាប់បើវិនិយក។ ច្បាប់ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 2534-688-800-1/612-676-6810).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

## **ABIRATERONE\_(UCARE)\_2025**

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### **MEDICATION(S)**

ABIRATERONE ACETATE, ABIRTEGA

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Prostate Cancer-Regional Risk Group, Prostate cancer-very-high-risk group, Prostate cancer-radical prostatectomy

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For Metastatic Castration-Resistant Prostate Cancer (mCRPC): Approve if abiraterone is being used in combination with prednisone or dexamethasone and the medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, or the medication is concurrently used with Firmagon or Orgovyx or the member has had a bilateral orchiectomy. For Metastatic Castration-Sensitive Prostate Cancer: Approve if the medication is used in combination with prednisone and the medication is concurrently used with a GnRH agonist or concurrently used with Firmagon or Orgovyx or the member has had a bilateral orchiectomy. For Prostate Cancer - Regional Risk Group: Approve if the member meets all of the following criteria (A, B, and C): A) abiraterone is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i, ii or iii): i. abiraterone with prednisone is used in

combination with GnRH agonist OR ii. Patient has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon or Orgovyx. For Prostate Cancer - Very High Risk Group: Approve if according to the prescriber the member is in the very-high-risk group, the medication will be used in combination with external beam radiation therapy and the member meets one of the following criteria (i, ii or iii): i. abiraterone is used in combination with GnRH agonist OR ii. Member has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon or Orgovyx. For Prostate Cancer Following a Radical Prostatectomy: Approve if the medication is used in combination with prednisone, AND the member has prostate specific antigen (PSA) persistence or recurrence following radical prostatectomy or member has pelvic recurrence, AND the medication will be used concurrently with GnRH agonist, Firmagon or Orgovyx or the member has had a bilateral orchiectomy.

## **PART B PREREQUISITE**

N/A

## **ACNE AGENTS\_NVT\_2025**

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### **MEDICATION(S)**

AVITA 0.025 % CREAM, TRETINOIN 0.025 % CREAM, TRETINOIN 0.05 % CREAM, TRETINOIN 0.1 % CREAM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ACTEMRA\_(UCARE)\_2025**

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### **MEDICATION(S)**

ACTEMRA 162 MG/0.9ML SOLN PRSYR, ACTEMRA ACTPEN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima, adalimumab-aaty, or Simlandi, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Xeljanz, or d) Rinvoq. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For rheumatoid arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **ACTIMMUNE\_NVT\_2025**

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### **MEDICATION(S)**

ACTIMMUNE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ADALIMUMAB-AATY\_(UCARE)\_2025**

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### **MEDICATION(S)**

ADALIMUMAB-AATY (1 PEN), ADALIMUMAB-AATY (2 PEN), ADALIMUMAB-AATY (2 SYRINGE),  
ADALIMUMAB-AATY CD/UC/HS START

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis, psoriatic arthritis, or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.

**COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **ADBRY\_(UCARE)\_2025**

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### **MEDICATION(S)**

ADBRY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For atopic dermatitis (continuation requests): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

**PART B PREREQUISITE**

N/A

## **ADCIRCA\_NVT\_2025**

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### **MEDICATION(S)**

ALYQ, TADALAFIL (PAH)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **AFINITOR\_NVT\_2025**

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### **MEDICATION(S)**

EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB, EVEROLIMUS 5 MG TAB SOL, EVEROLIMUS 7.5 MG TAB, TORPENZ

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **AIMOVIG\_(UCARE)\_2025**

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### **MEDICATION(S)**

AIMOVIG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **AJOVY\_NVT\_2025**

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### **MEDICATION(S)**

AJOVY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: Member has 4 or more migraine days per month for the previous 3 months or longer. For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **AKEEGA\_NVT\_2025**

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### **MEDICATION(S)**

AKEEGA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ALECENSA\_NVT\_2025**

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### **MEDICATION(S)**

ALECENSA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ALUNBRIG\_NVT\_2025**

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### **MEDICATION(S)**

ALUNBRIG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ALYFTREK\_NVT\_2025**

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### **MEDICATION(S)**

ALYFTREK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ARCALYST\_NVT\_2025**

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### **MEDICATION(S)**

ARCALYST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ARIKAYCE\_NVT\_2025**

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### **MEDICATION(S)**

ARIKAYCE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ATTRUBY\_NVT\_2025**

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### **MEDICATION(S)**

ATTRUBY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM)(initial requests): Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive Congo Red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining or B) Non-invasive testing demonstrating all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65, ii) Absence of monoclonal protein via serum protein immunofixation, iii) Absence of monoclonal protein via urine protein immunofixation and iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For ATTR-CM (continuation requests): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For ATTR-CM: Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of ATTR-CM.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For ATTR-CM (all requests): Will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro), vutrisiran (Amvuttra) or tafamidis (Vyndaqel/Vyndamax).

**PART B PREREQUISITE**

N/A

## **AUGTYRO\_NVT\_2025**

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### **MEDICATION(S)**

AUGTYRO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **AUSTEDO\_NVT\_2025**

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### **MEDICATION(S)**

AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist or psychiatrist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

# **AVMAPKI FAKZYNJA\_NVT\_2025**

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## **MEDICATION(S)**

AVMAPKI FAKZYNJA CO-PACK

## **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

## **OFF LABEL USES**

N/A

## **EXCLUSION CRITERIA**

N/A

## **REQUIRED MEDICAL INFORMATION**

N/A

## **AGE RESTRICTION**

N/A

## **PREScriBER RESTRICTION**

N/A

## **COVERAGE DURATION**

Approved for duration of 1 year.

## **OTHER CRITERIA**

N/A

## **PART B PREREQUISITE**

N/A

## **AYVAKIT\_NVT\_2025**

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### **MEDICATION(S)**

AYVAKIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BALVERSA\_NVT\_2025**

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### **MEDICATION(S)**

BALVERSA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BANZEL\_NVT\_2025**

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### **MEDICATION(S)**

RUFINAMIDE 200 MG TAB, RUFINAMIDE 400 MG TAB, RUFINAMIDE 40 MG/ML SUSPENSION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of at least one anti-epileptic medication was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BENLYSTA\_NVT\_2025**

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### **MEDICATION(S)**

BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For systemic lupus erythematosus initial requests: Two of the following were ineffective or not tolerated: a) hydroxychloroquine, b) methotrexate, c) azathioprine, d) mycophenolate OR e) a corticosteroid. For all requests: Prescriber attests that member does not have severe active CNS lupus AND member is not taking other biologics. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a rheumatology specialist, nephrologist, or dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL OR B) low complement (C3/C4) OR C) positive for anti-Smith antibodies. For systemic lupus erythematosus (all requests): Will not be given in combination with other biologics. For active lupus nephritis (all requests): Will not be used in combination with voclosporin (Lupkynis).

### **PART B PREREQUISITE**

N/A

## **BESREMI\_NVT\_2025**

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### **MEDICATION(S)**

BESREMI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

One of the following was ineffective or not tolerated: A) hydroxyurea OR B) peginterferon alfa-2a.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BOMYNTRA\_NVT\_2025**

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### **MEDICATION(S)**

BOMYNTRA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BOSULIF\_NVT\_2025**

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### **MEDICATION(S)**

BOSULIF

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BRAFTOVI\_NVT\_2025**

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### **MEDICATION(S)**

BRAFTOVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **BRUKINSA\_NVT\_2025**

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### **MEDICATION(S)**

BRUKINSA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CABOMETYX\_NVT\_2025**

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### **MEDICATION(S)**

CABOMETYX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CALQUENCE\_NVT\_2025**

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### **MEDICATION(S)**

CALQUENCE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CAPLYTA\_NVT\_2025**

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### **MEDICATION(S)**

CAPLYTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine. For bipolar depression: Two of the following were ineffective or not tolerated: a) lurasidone, b) quetiapine, or c) asenapine.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CAPRELSA\_NVT\_2025**

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### **MEDICATION(S)**

CAPRELSA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CARBAGLU\_NVT\_2025**

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### **MEDICATION(S)**

CARGLUMIC ACID

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CAYSTON\_NVT\_2025**

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### **MEDICATION(S)**

CAYSTON

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CIALIS\_NVT\_2025**

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### **MEDICATION(S)**

TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **COBENFY\_NVT\_2025**

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### **MEDICATION(S)**

COBENFY, COBENFY STARTER PACK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **COMETRIQ\_NVT\_2025**

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### **MEDICATION(S)**

COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CONTINUOUS GLUCOSE MONITORS\_UCARE\_2025**

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### **MEDICATION(S)**

DEXCOM G5 MOB/G4 PLAT SENSOR, DEXCOM G5 MOBILE RECEIVER, DEXCOM G5 MOBILE TRANSMITTER, DEXCOM G5 RECEIVER KIT, DEXCOM G6 RECEIVER, DEXCOM G6 SENSOR, DEXCOM G6 TRANSMITTER, DEXCOM G7 15 DAY SENSOR, DEXCOM G7 RECEIVER, DEXCOM G7 SENSOR, FREESTYLE LIBRE 14 DAY READER, FREESTYLE LIBRE 14 DAY SENSOR, FREESTYLE LIBRE 2 PLUS SENSOR, FREESTYLE LIBRE 2 READER, FREESTYLE LIBRE 2 SENSOR, FREESTYLE LIBRE 3 PLUS SENSOR, FREESTYLE LIBRE 3 READER, FREESTYLE LIBRE 3 SENSOR, FREESTYLE LIBRE READER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 3 years.

### **OTHER CRITERIA**

For Diabetes Mellitus (Initial Requests) - Approve if the member has been treated with insulin in the past 180 days OR has a history of problematic hypoglycemia with documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose less than 54mg/dL (3.0mmol/L) that persist despite multiple (2 or more) attempts to adjust medication(s) and/or modify the diabetes treatment plan, or, a history of one level 3 hypoglycemic event (glucose less than 54mg/dL (3.0mmol/L) characterized

by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia, AND the member (or the member's caregiver) must have been properly trained on using the requested continuous glucose monitor (CGM) as evidenced by the treating practitioner providing a prescription, AND the CGM is prescribed according to its Food and Drug Administration (FDA) indicated use, AND the prescriber has had an in-person visit or approved telehealth visit with the member within the past six months, prior to ordering the CGM, to evaluate their diabetes control. For Diabetes Mellitus (Continuation Requests) - Approve if the treating practitioner conducts an in-person or Medicare-approved telehealth visit with the member to document adherence to their CGM regimen and diabetes treatment plan every six months following the initial prescription of the CGM.

## **PART B PREREQUISITE**

N/A

## **COPIKTRA\_NVT\_2025**

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### **MEDICATION(S)**

COPIKTRA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **COSENTYX\_NVT\_2025**

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### **MEDICATION(S)**

COSENTYX 150 MG/ML SOLN PRSYR, COSENTYX 75 MG/0.5ML SOLN PRSYR, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For ankylosing spondylitis (all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For psoriatic arthritis, non-radiographic axial spondyloarthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **COTELLIC\_NVT\_2025**

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### **MEDICATION(S)**

COTELLIC

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CYSTARAN\_NVT\_2025**

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### **MEDICATION(S)**

CYSTARAN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **CYSTEAMINE\_(UCARE)\_2025**

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### **MEDICATION(S)**

CYSTAGON

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

Concomitant use of Cystagon and Procysbi

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For nephrotic cystinosis: Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For Nephrotic Cystinosis (initial requests): Approve if the prescriber attests the diagnosis was established by genetic testing confirming a mutation of the CTNS gene OR the member has a white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory. For Nephrotic Cystinosis (continuation requests): Approve if the member has had a clinical benefit (e.g., decrease in white blood cell cystine levels from baseline) with the requested medication.

### **PART B PREREQUISITE**

N/A

## **DALFAMPRIDINE\_(UCARE)\_2025**

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### **MEDICATION(S)**

DALFAMPRIDINE ER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

For multiple sclerosis (MS): 18 years and older

### **PRESCRIBER RESTRICTION**

For multiple sclerosis (MS): Prescribed by or in consultation with a neurologist or MS specialist.

### **COVERAGE DURATION**

Initial approval duration of 4 months. Continuing therapy approved for a duration of 1 year.

### **OTHER CRITERIA**

For MS (initial requests): Approve if the member is ambulatory, AND the requested medication is being used to improve or maintain mobility in a member with MS AND the member has impaired ambulation as evaluated by an objective measure (e.g., timed 25 foot walk and multiple sclerosis walking scale-12). For MS (continuation requests): Approve if the member is ambulatory, AND the requested medication is being used to improve or maintain mobility in a member with MS, AND the member has responded to or is benefiting from therapy.

### **PART B PREREQUISITE**

N/A

## **DARAPRIM\_(UCARE)\_2025**

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### **MEDICATION(S)**

PYRIMETHAMINE 25 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DAURISMO\_NVT\_2025**

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### **MEDICATION(S)**

DAURISMO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DEM SER\_NVT\_2025**

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### **MEDICATION(S)**

METYROSINE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DIACOMIT\_NVT\_2025**

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### **MEDICATION(S)**

DIACOMIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of at least one anti-epileptic medication was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **DRONABINOL\_NVT\_2025**

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### **MEDICATION(S)**

DRONABINOL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Approval will be based off BvD coverage determination.

### **PART B PREREQUISITE**

N/A

## **DUPIXENT\_NVT\_2025**

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### **MEDICATION(S)**

DUPIXENT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: For atopic dermatitis: Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For asthma: History, within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Trial of a nasal corticosteroid was ineffective or not tolerated. For eosinophilic esophagitis: Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis: Trial of other agents not required. For chronic obstructive pulmonary disease (COPD): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving long-acting muscarinic antagonist/long-acting beta-agonist/inhaled corticosteroid maintenance triple therapy. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment. For bullous pemphigoid (BP)(initial requests): Both of the following: a) Trial of an oral corticosteroid was ineffective or not tolerated and b) One of the following was ineffective or not tolerated: i) methotrexate, ii) azathioprine, or iii) mycophenolate mofetil. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For all indications, must be prescribed by, or in consultation with, one of the specialists listed. For

atopic dermatitis or chronic spontaneous urticaria: Allergist, immunologist, or dermatologist. For asthma or COPD: Allergist, pulmonologist, or immunologist. For nasal polyps: Allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Allergist or gastroenterologist. For BP: Prescribed by, or in consultation with, a dermatologist.

## **COVERAGE DURATION**

Approved for duration of 1 year.

## **OTHER CRITERIA**

For initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter) OR 2) Oral corticosteroid-dependent asthma requiring daily doses of 5 mg or greater prednisone (or equivalent). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis: Both of the following apply: a) diagnosis has persisted for at least 6 weeks, AND b) nodules present at baseline. For COPD: Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For BP (initial requests): Both of the following: a) BP Disease Area Index (BDAI) activity score greater than or equal to 24 and b) BP is not drug-induced. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

## **PART B PREREQUISITE**

N/A

## **EMGALITY\_NVT\_2025**

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### **MEDICATION(S)**

EMGALITY, EMGALITY (300 MG DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For migraine initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis initial requests: Trial of verapamil was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ENBREL\_NVT\_2025**

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### **MEDICATION(S)**

ENBREL 25 MG/0.5ML SOLN PRSYR, ENBREL 25 MG/0.5ML SOLUTION, ENBREL 50 MG/ML SOLN PRSYR, ENBREL MINI, ENBREL SURECLICK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For juvenile psoriatic arthritis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For rheumatoid arthritis, psoriatic arthritis, juvenile psoriatic arthritis, or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **ENDARI\_NVT\_2025**

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### **MEDICATION(S)**

L-GLUTAMINE 5 GM PACKET

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a hematologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **EPCLUSANVT\_2025**

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### **MEDICATION(S)**

SOFOSBUVIR-VELPATASVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

1) Current HCV-RNA titer is provided 2) Member has not had prior treatment with a direct-acting antiviral for current hepatitis C infection 3) One of the following: a) Member does not have cirrhosis or b) Member has compensated cirrhosis and one of the following: i) Does not have genotype 3 or ii) has genotype 3 but no NS5A resistance-associated substitution Y93H or c) Member has decompensated cirrhosis AND will receive weight-based ribavirin.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.

### **COVERAGE DURATION**

Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **EPIDIOLEX\_NVT\_2025**

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### **MEDICATION(S)**

EPIDIOLEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of at least one anti-epileptic medication was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ERIVEDGE\_NVT\_2025**

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### **MEDICATION(S)**

ERIVEDGE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ERLEADA\_NVT\_2025**

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### **MEDICATION(S)**

ERLEADA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated.  
For nonmetastatic castration-resistant prostate cancer: Trial of other agents not required.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ESBRIET\_NVT\_2025**

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### **MEDICATION(S)**

PIRFENIDONE 267 MG CAP, PIRFENIDONE 267 MG TAB, PIRFENIDONE 801 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For idiopathic pulmonary fibrosis initial requests: Diagnosis confirmed by one of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography indicates definite UIP pattern 3) Both High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **EXXUA\_NVT\_2025**

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### **MEDICATION(S)**

EXXUA, EXXUA TITRATION PACK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Two of the following were ineffective or not tolerated: a) escitalopram, b) sertraline, c) fluoxetine, d) citalopram, e) paroxetine, f) fluvoxamine, g) bupropion, h) venlafaxine i) desvenlafaxine, or j) duloxetine.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FANAPT\_NVT\_2025**

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### **MEDICATION(S)**

FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) asenapine.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FASENRA\_NVT\_2025**

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### **MEDICATION(S)**

FASENRA, FASENRA PEN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For asthma (initial requests): History within the last year of at least 1 asthma exacerbation requiring one of following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA)(initial requests): Trial of oral corticosteroid therapy was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For asthma: Prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist. For EGPA: Prescribed by, or in consultation with, a rheumatology specialist, allergist, pulmonologist, or immunologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

**PART B PREREQUISITE**

N/A

## **FINTEPLA\_NVT\_2025**

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### **MEDICATION(S)**

FINTEPLA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of at least one anti-epileptic medication was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FIRDAPSE\_NVT\_2025**

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### **MEDICATION(S)**

FIRDAPSE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by one of the following: a) Presence of voltage-gated calcium channel antibodies OR b) electrophysiologic compound muscle action potential test findings are consistent with LEMS.

### **PART B PREREQUISITE**

N/A

## **FIRMAGON\_NVT\_2025**

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### **MEDICATION(S)**

FIRMAGON, FIRMAGON (240 MG DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FOTIVDA\_NTV\_2025**

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### **MEDICATION(S)**

FOTIVDA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FRUZAQLA\_NVT\_2025**

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### **MEDICATION(S)**

FRUZAQLA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **FYCOMPA\_NVT\_2025**

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### **MEDICATION(S)**

FYCOMPA 0.5 MG/ML SUSPENSION, PERAMPANEL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For partial-onset seizures: Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate OR g) lacosamide. For primary generalized tonic-clonic seizures: Two of the following were ineffective or not tolerated: a) lamotrigine, b) levetiracetam, c) primidone OR d) topiramate.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **GAVRETO\_NVT\_2025**

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### **MEDICATION(S)**

GAVRETO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **GILOTrif\_NVT\_2025**

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### **MEDICATION(S)**

GILOTrif

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **GLP-1 AGONISTS (UCARE) 2025**

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### **MEDICATION(S)**

BYDUREON BCISE, MOUNJARO, OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN, OZEMPIC (2 MG/DOSE), RYBELSUS, TRULICITY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Continuation therapy (all FDA approved indications): Approve if the member has been using the requested medication within the past 180 days.

### **PART B PREREQUISITE**

N/A

## **GOMEKLI\_NVT\_2025**

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### **MEDICATION(S)**

GOMEKLI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **GROWTH HORMONES\_NVT\_2025**

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### **MEDICATION(S)**

OMNITROPE, SKYTROFA 11 MG CARTRIDGE, SKYTROFA 13.3 MG CARTRIDGE, SKYTROFA 3.6 MG CARTRIDGE, SKYTROFA 3 MG CARTRIDGE, SKYTROFA 4.3 MG CARTRIDGE, SKYTROFA 5.2 MG CARTRIDGE, SKYTROFA 6.3 MG CARTRIDGE, SKYTROFA 7.6 MG CARTRIDGE, SKYTROFA 9.1 MG CARTRIDGE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **HADLIMA\_NVT\_2025**

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### **MEDICATION(S)**

HADLIMA, HADLIMA PUSHTOUCH

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis, psoriatic arthritis, or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.

**COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **HAE AGENTS\_NVT\_2025**

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### **MEDICATION(S)**

HAEGARDA, ICATIBANT ACETATE, SAJAZIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For medications indicated for long-term prophylaxis (all requests): Will not be used in combination with another agent for long-term prophylaxis of hereditary angioedema attacks.

### **PART B PREREQUISITE**

N/A

## **HARVONI\_(UCARE)\_2025**

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### **MEDICATION(S)**

LEDIPASVIR-SOFOSBUVIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

1) Genotype is provided 2) Current HCV-RNA titer is provided 3) Member has one of the following: a) no cirrhosis, b) compensated cirrhosis, or c) decompensated cirrhosis 4) Member has not had prior treatment with a direct-acting antiviral for current hepatitis C infection 5) Member is intolerant to, or unable to use both of the following: a) Mavyret and b) Sofosbuvir-Velpatasvir.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.

### **COVERAGE DURATION**

Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **HERNEXEOS\_NVT\_2025**

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### **MEDICATION(S)**

HERNEXEOS

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **HRM\_BENZODIAZEPINES\_(UCARE)\_2025**

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### **MEDICATION(S)**

ALPRAZOLAM 0.25 MG TAB, ALPRAZOLAM 0.5 MG TAB, ALPRAZOLAM 1 MG TAB, ALPRAZOLAM 2 MG TAB, CLONAZEPAM 0.125 MG TAB DISP, CLONAZEPAM 0.25 MG TAB DISP, CLONAZEPAM 0.5 MG TAB, CLONAZEPAM 0.5 MG TAB DISP, CLONAZEPAM 1 MG TAB, CLONAZEPAM 1 MG TAB DISP, CLONAZEPAM 2 MG TAB, CLONAZEPAM 2 MG TAB DISP, CLONAZEPAM 0.125 MG TAB DISP, CLONAZEPAM 0.25 MG TAB DISP, CLONAZEPAM 0.5 MG TAB, CLONAZEPAM 0.5 MG TAB DISP, CLONAZEPAM 1 MG TAB, CLONAZEPAM 1 MG TAB DISP, CLONAZEPAM 2 MG TAB, CLONAZEPAM 2 MG TAB DISP, CLORAZEPATE DIPOTASSIUM, DIAZEPAM 10 MG TAB, DIAZEPAM 2 MG TAB, DIAZEPAM 5 MG/5ML SOLUTION, DIAZEPAM 5 MG/ML CONC, DIAZEPAM 5 MG TAB, DIAZEPAM 10 MG TAB, DIAZEPAM 2 MG TAB, DIAZEPAM 5 MG/5ML SOLUTION, DIAZEPAM 5 MG/ML CONC, DIAZEPAM 5 MG TAB, DIAZEPAM INTENSOL, LORAZEPAM 0.5 MG TAB, LORAZEPAM 1 MG TAB, LORAZEPAM 2 MG/ML CONC, LORAZEPAM 2 MG TAB, LORAZEPAM INTENSOL, OXAZEPAM, TEMAZEPAM 15 MG CAP, TEMAZEPAM 30 MG CAP

### **PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

Patients under the age of 65 years: approve. Patients aged 65 years and older: other criteria apply.

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Procedure-related sedation: Approved for 1 month. All other conditions: Approved for 1 year.

### **OTHER CRITERIA**

For Insomnia: Approve lorazepam, temazepam, or oxazepam if the member has had a trial of two of the following: ramelteon, trazodone, doxepin 3mg or 6 mg, AND the physician has assessed risk versus benefit for the member and has confirmed they would still like to initiate/continue therapy. All medically accepted indications other than insomnia: Approve if the physician has assessed risk versus benefit for the member and has confirmed they would still like to initiate/continue therapy.

## **PART B PREREQUISITE**

N/A

## **IBRANCE\_NVT\_2025**

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### **MEDICATION(S)**

IBRANCE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **IBTROZI\_NVT\_2025**

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### **MEDICATION(S)**

IBTROZI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ICLUSIG\_NVT\_2025**

---

### **MEDICATION(S)**

ICLUSIG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **IDHIFA\_NVT\_2025**

---

### **MEDICATION(S)**

IDHIFA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **IMATINIB\_(UCARE)\_2025**

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### **MEDICATION(S)**

IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Chordoma, advanced, aggressive or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor, myeloid/lymphoid neoplasms with eosinophilia.

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.

### **AGE RESTRICTION**

For aggressive systemic mastocytosis (ASM), dermatofibrosarcoma protuberans (DFSP), hypereosinophilic syndrome (HES), myelodysplastic syndrome (MDS), myeloproliferative disease (MDP), or Myeloid/Lymphoid Neoplasms: 18 years and older

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Acute myeloid leukemia (ALL) or chronic myeloid leukemia (CML): Approve if the member has Philadelphia chromosome-positive disease. Kaposi's Sarcoma: Approve if the member has tried at least one prior regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT): Approve if the member has tried Turalio or, according to the prescriber, the patient cannot take Turalio. Myelodysplastic/myeloproliferative disease: Approve if the condition is associated with platelet-derived growth factor receptor (PDGFR) gene

rearrangements. Chronic Graft versus host disease (GVHD): Approve if the member has tried at least one conventional systemic treatment (e.g., prednisone, Imbruvica, Jakafi). Metastatic melanoma: Approve if the member has an activating C-KIT mutation, AND is ineligible for or unresponsive to more effective therapies (i.e., immune checkpoint inhibitors, BRAF-targeted therapy), according to the prescriber, AND has advanced or recurrent metastatic melanoma. Myeloid/lymphoid neoplasms with eosinophilia: Approve if the tumor has one of the following (a, b, or c): a) ABL1 rearrangement, or b) FIP1L1-PDGFR $\alpha$ , or c) PDGFR $\beta$  rearrangement.

## **PART B PREREQUISITE**

N/A

## **IMBRUVICA\_NVT\_2025**

---

### **MEDICATION(S)**

IMBRUVICA 140 MG CAP, IMBRUVICA 420 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **IMKELDI\_NVT\_2025**

---

### **MEDICATION(S)**

IMKELDI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Member is unable to swallow solid dosage forms of imatinib.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INCRELEX\_NVT\_2025**

---

### **MEDICATION(S)**

INCRELEX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INGREZZA\_NVT\_2025**

---

### **MEDICATION(S)**

INGREZZA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist or psychiatrist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INLURIYO\_NVT\_2025**

---

### **MEDICATION(S)**

INLURIYO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INLYTA\_NVT\_2025**

---

### **MEDICATION(S)**

INLYTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INQOVI\_NVT\_2025**

---

### **MEDICATION(S)**

INQOVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **INREBIC\_NVT\_2025**

---

### **MEDICATION(S)**

INREBIC

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of Jakafi was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **IRESSA\_NVT\_2025**

---

### **MEDICATION(S)**

GEFITINIB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ITOVEBI\_NVT\_2025**

---

### **MEDICATION(S)**

ITOVEBI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ITRACONAZOLE\_(UCARE)\_2025**

---

### **MEDICATION(S)**

ITRACONAZOLE 100 MG CAP, ITRACONAZOLE 10 MG/ML SOLUTION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for a duration of 6 months.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

**MEDICATION(S)**

GAMMAKED, GAMUNEX-C, PRIVIGEN

**PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

**OFF LABEL USES**

N/A

**EXCLUSION CRITERIA**

N/A

**REQUIRED MEDICAL INFORMATION**

N/A

**AGE RESTRICTION**

N/A

**PREScriBER RESTRICTION**

N/A

**COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

Approval will be based off BvD coverage determination.

**PART B PREREQUISITE**

N/A

## **IWILFIN\_NVT\_2025**

---

### **MEDICATION(S)**

IWILFIN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **JADENU\_NVT\_2025**

---

### **MEDICATION(S)**

DEFERASIROX 180 MG TAB, DEFERASIROX 360 MG TAB, DEFERASIROX 90 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

Prescribed by or in consultation with a hematologist

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **JAKAFI\_NVT\_2025**

---

### **MEDICATION(S)**

JAKAFI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **JAYPIRCA\_NVT\_2025**

---

### **MEDICATION(S)**

JAYPIRCA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **JOURNAVX\_(UCARE)\_2025**

---

### **MEDICATION(S)**

JOURNAVX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 month

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KALYDECO\_NVT\_2025**

---

### **MEDICATION(S)**

KALYDECO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KERENDIA\_NVT\_2025**

---

### **MEDICATION(S)**

KERENDIA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KEVZARA\_(UCARE)\_2025**

---

### **MEDICATION(S)**

KEVZARA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Rinvoq OR d) Xeljanz. For polymyalgia rheumatica (initial requests), one of the following: a) a trial of a corticosteroid was ineffective OR b) member was unable to tolerate a corticosteroid taper to less than or equal to 5 mg prednisone equivalent per day. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Xeljanz, OR d) Rinvoq. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis and polymyalgia rheumatica: Prescribed by, or in consultation with, a rheumatology specialist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KISQALI\_NVT\_2025**

---

### **MEDICATION(S)**

KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE), KISQALI FEMARA (200 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KORLYM\_NVT\_2025**

---

### **MEDICATION(S)**

MIFEPRISTONE 300 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KOSELUGO\_NVT\_2025**

---

### **MEDICATION(S)**

KOSELUGO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Chart notes documentation is provided that indicates inoperable and symptomatic disease

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KRAZATI\_NVT\_2025**

---

### **MEDICATION(S)**

KRAZATI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **KUVAN\_NVT\_2025**

---

### **MEDICATION(S)**

SAPROPTERIN DIHYDROCHLORIDE 100 MG PACKET, SAPROPTERIN DIHYDROCHLORIDE 500 MG PACKET

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For continuation therapy: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a medical geneticist or metabolic physician.

### **COVERAGE DURATION**

Initial approval of 3 months. Continuing therapy approved for 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LAZCLUZE\_NVT\_2025**

---

### **MEDICATION(S)**

LAZCLUZE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LENVIMA\_NVT\_2025**

---

### **MEDICATION(S)**

LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG 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 INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LETAIRIS\_NVT\_2025**

---

### **MEDICATION(S)**

AMBRISENTAN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LIBERVANT\_NVT\_2025**

---

### **MEDICATION(S)**

LIBERVANT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LIDOCAINE\_PATCH\_(UCARE)\_2025**

---

### **MEDICATION(S)**

LIDOCAINE PATCHES

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Diabetic neuropathic pain, chronic back pain

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LIVTENCITY\_NVT\_2025**

---

### **MEDICATION(S)**

LIVTENCITY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Prescriber attests that the medication will not be used for CMV infection prophylaxis.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.

### **COVERAGE DURATION**

Approved for 3 months.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LONG\_ACTING\_OPIOIDS\_(UCARE)\_2025**

---

### **MEDICATION(S)**

BELBUCA, BUPRENORPHINE, FENTANYL 100 MCG/HR PATCH 72HR, FENTANYL 12 MCG/HR PATCH 72HR, FENTANYL 25 MCG/HR PATCH 72HR, FENTANYL 50 MCG/HR PATCH 72HR, FENTANYL 75 MCG/HR PATCH 72HR, FENTANYL 100 MCG/HR PATCH 72HR, FENTANYL 12 MCG/HR PATCH 72HR, FENTANYL 25 MCG/HR PATCH 72HR, FENTANYL 50 MCG/HR PATCH 72HR, FENTANYL 75 MCG/HR PATCH 72HR, METHADONE HCL 10 MG TAB, METHADONE HCL 5 MG TAB, METHADONE HCL 10 MG/5ML SOLUTION, METHADONE HCL 5 MG/5ML SOLUTION, MORPHINE SULFATE ER 100 MG TAB ER, MORPHINE SULFATE ER 15 MG TAB ER, MORPHINE SULFATE ER 200 MG TAB ER, MORPHINE SULFATE ER 30 MG TAB ER, MORPHINE SULFATE ER 60 MG TAB ER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

Acute (i.e., non-chronic) pain

### **REQUIRED MEDICAL INFORMATION**

Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For pain severe enough to require daily, around-the-clock, long-term opioid treatment (initial and continuation): Approve if all of the following criteria are met: 1) member is not opioid naive, AND 2)

non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, in hospice, sickle cell disease or who reside in a long term care facility are not required to meet above criteria.

## **PART B PREREQUISITE**

N/A

## **LONSURF\_NVT\_2025**

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### **MEDICATION(S)**

LONSURF

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LORBRENA\_NVT\_2025**

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### **MEDICATION(S)**

LORBRENA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LUMAKRAS\_NVT\_2025**

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### **MEDICATION(S)**

LUMAKRAS

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LYNPARZA\_NVT\_2025**

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### **MEDICATION(S)**

LYNPARZA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **LYTGOBI\_NVT\_2025**

---

### **MEDICATION(S)**

LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MAVYRET\_NVT\_2025**

---

### **MEDICATION(S)**

MAVYRET

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

1) Current HCV-RNA titer is provided 2) Member does not have decompensated cirrhosis 3) One of the following: a) member has not had prior treatment with a direct-acting antiviral for current hepatitis C infection or b) prior treatment with sofosbuvir-based regimen and all of the following: i) Member does not have genotype 3 and ii) No prior treatment with an NS3/4A protease inhibitor.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a gastroenterologist, hepatologist, infectious disease or transplant specialist.

### **COVERAGE DURATION**

Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MEGESTROL SUSP\_NVT\_2025**

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### **MEDICATION(S)**

MEGESTROL ACETATE 400 MG/10ML SUSPENSION, MEGESTROL ACETATE 40 MG/ML SUSPENSION, MEGESTROL ACETATE 625 MG/5ML SUSPENSION, MEGESTROL ACETATE 800 MG/20ML SUSPENSION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MEGESTROL TABS\_NVT\_2025**

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### **MEDICATION(S)**

MEGESTROL ACETATE 20 MG TAB, MEGESTROL ACETATE 40 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MEKINIST\_NVT\_2025**

---

### **MEDICATION(S)**

MEKINIST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MEKTOVI\_NVT\_2025**

---

### **MEDICATION(S)**

MEKTOVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MIGRANAL\_NVT\_2025**

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### **MEDICATION(S)**

DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of two different triptans was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MODAFINIL\_ARMODAFINIL\_(UCARE)\_2025**

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### **MEDICATION(S)**

ARMODAFINIL, MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only.  
Adjunctive/augmentation for treatment of depression in adults - modafinil only. Fatigue due to multiple sclerosis - modafinil only. Idiopathic hypersomnia - modafinil only.

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

Fatigue due to multiple sclerosis and Idiopathic hypersomnia - 18 years of age and older. All others - 17 years of age and older.

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Excessive daytime sleepiness associated with Shift Work Sleep Disorder (SWSD): Approve if the member is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults: Approve modafinil if the member is concurrently receiving at least one other medication for the treatment of depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome: Approve modafinil or armodafinil. Excessive daytime sleepiness associated with Narcolepsy: Approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Fatigue due to multiple sclerosis: Approve modafinil. Idiopathic hypersomnia: Approve modafinil. Excessive daytime sleepiness (EDS) associated with myotonic

dystrophy: Approve modafinil.

**PART B PREREQUISITE**

N/A

## **MODEYSO\_NVT\_2025**

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### **MEDICATION(S)**

MODEYSO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **MS\_AGENTS\_(UCARE)\_2025**

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### **MEDICATION(S)**

AVONEX PEN, AVONEX PREFILLED, DIMETHYL FUMARATE 120 MG CAP DR, DIMETHYL FUMARATE 240 MG CAP DR, DIMETHYL FUMARATE STARTER PACK, FINGOLIMOD HCL, GLATIRAMER ACETATE, GLATOPA, KESIMPTA, PLEGRIDY, TERIFLUNOMIDE, VUMERITY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis. For Avonex, Kesimpta, Plegridy, and Vumerity, must first try one of the following: teriflunomide, dimethyl fumarate, fingolimod, or glatiramer acetate.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NEMLUVIO\_NVT\_2025**

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### **MEDICATION(S)**

NEMLUVIO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) A medium to very high potency topical steroid, b) A topical calcineurin inhibitor or c) An oral immunosuppressant. For prurigo nodularis (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more or b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas and 2) At least two of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin or c) impaired activities of daily living. For prurigo nodularis (initial requests): Both of the following apply: a) diagnosis has persisted for at least 6 weeks, AND b) nodules present at baseline. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

**PART B PREREQUISITE**

N/A

## **NERLYNX\_NVT\_2025**

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### **MEDICATION(S)**

NERLYNX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NEXAVAR\_NVT\_2025**

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### **MEDICATION(S)**

SORAFENIB TOSYLATE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NEXVIAZYME\_UCARE\_2025**

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### **MEDICATION(S)**

NEXVIAZYME

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

For Acid Alpha-Glucosidase Deficiency (Pompe Disease): 1 year of age or older

### **PREScriBER RESTRICTION**

For Acid Alpha-Glucosidase Deficiency (Pompe Disease): Prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For Acid Alpha-Glucosidase Deficiency (Pompe Disease): Approve if the member has late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) and the diagnosis is established by one of the following: a laboratory test demonstrating deficient acid alphaglucosidase activity in blood, fibroblasts, or muscle tissue or a molecular genetic test demonstrating acid alpha-glucosidase gene mutation.

### **PART B PREREQUISITE**

N/A

## **NILUTAMIDE\_(UCARE)\_2025**

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### **MEDICATION(S)**

NILUTAMIDE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For Prostate Cancer: Approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.

### **PART B PREREQUISITE**

N/A

## **NINLARO\_NVT\_2025**

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### **MEDICATION(S)**

NINLARO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NORTHERA\_NVT\_2025**

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### **MEDICATION(S)**

DROXIDOPA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NOXAFIL\_NVT\_2025**

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### **MEDICATION(S)**

POSACONAZOLE 100 MG TAB DR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NUBEQA\_NVT\_2025**

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### **MEDICATION(S)**

NUBEQA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For metastatic hormone-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated.

For non-metastatic castration-resistant prostate cancer: Trial of other agents not required.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NUEDEXTA\_NVT\_2025**

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### **MEDICATION(S)**

NUEDEXTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect. For continuation requests, both of the following: A) Documentation is provided (in the form of chart notes or imaging) of structural neurological condition as the cause of pseudobulbar affect AND B) Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NUPLAZID\_NVT\_2025**

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### **MEDICATION(S)**

NUPLAZID

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **NURTEC\_(UCARE)\_2025**

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### **MEDICATION(S)**

NURTEC

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests for acute treatment of migraines: Member has tried at least two different triptan therapies (e.g., sumatriptan and rizatriptan) or has a contraindication to triptans according to the prescriber. For initial requests for the prevention of episodic migraines: Member has had an 8-week or greater trial of two of the three following drug classes which were ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OCTREOTIDE\_NVT\_2025**

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### **MEDICATION(S)**

OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ODOMZO\_NVT\_2025**

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### **MEDICATION(S)**

ODOMZO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OFEV\_NVT\_2025**

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### **MEDICATION(S)**

OFEV

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

1) For idiopathic pulmonary fibrosis initial requests: A) Diagnosis confirmed by one of the following: i) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) ii) High-resolution computed tomography (HRCT) indicates definite UIP pattern iii) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP AND B) Trial of pirfenidone was ineffective or not tolerated. 2) For systemic sclerosis-associated interstitial lung disease (ILD) initial requests: A) Diagnosis confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND B) Trial of mycophenolate mofetil was ineffective or not tolerated. 3) For chronic fibrosing ILDs with a progressive phenotype initial requests: A) Disease is progressive, defined by one of the following over the past 12 months, with no alternative explanation: i) worsening respiratory symptoms, ii) one of the following: a) forced vital capacity (FVC) decline of 5% or more OR b) corrected hemoglobin decline of 10% or more OR iii) radiological evidence of disease progression AND B) Progression occurred despite treatment with one of the following: i) azathioprine ii) cyclosporine iii) mycophenolate mofetil iv) tacrolimus v) oral corticosteroids equivalent to 20 mg or more per day of prednisone vi) cyclophosphamide vii) rituximab. 4) For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **OGSIVEO\_NVT\_2025**

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### **MEDICATION(S)**

OGSIVEO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OBJEMDA\_NVT\_2025**

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### **MEDICATION(S)**

OBJEMDA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OJJAARA\_NVT\_2025**

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### **MEDICATION(S)**

OJJAARA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ONUREG\_NVT\_2025**

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### **MEDICATION(S)**

ONUREG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OPIPZA\_NVT\_2025**

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### **MEDICATION(S)**

OPIPZA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Both of the following: A) Member is unable to swallow aripiprazole tablet and B) Member is unable to use aripiprazole oral solution.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OPSUMIT\_NVT\_2025**

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### **MEDICATION(S)**

OPSUMIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ORENCIA\_(UCARE)\_2025**

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### **MEDICATION(S)**

ORENCIA 125 MG/ML SOLN PRSYR, ORENCIA 50 MG/0.4ML SOLN PRSYR, ORENCIA 87.5 MG/0.7ML SOLN PRSYR, ORENCIA CLICKJECT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima, adalimumab-aaty, or Simlandi, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Xeljanz, OR d) Rinvoq. For adult psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Cosentyx, d) Stelara or Steqeyma, e) Otezla, f) Skyrizi, g) Rinvoq OR h) Xeljanz. For pediatric psoriatic arthritis (initial requests): Trial of Enbrel was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis and psoriatic arthritis (adult and pediatric): Prescribed by, or in consultation with a rheumatology specialist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **ORGOVYX\_NVT\_2025**

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### **MEDICATION(S)**

ORGOVYX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ORKAMBI\_NVT\_2025**

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### **MEDICATION(S)**

ORKAMBI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ORSERDU\_NVT\_2025**

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### **MEDICATION(S)**

ORSERDU

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **OTEZLA\_NVT\_2025**

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### **MEDICATION(S)**

OTEZLA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For oral ulcers associated with Behcet's disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (all requests): Trial of other agents not required. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For oral ulcers associated with Behcet's disease and psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Plaque Psoriasis: Prescribed by, or in consultation with, a dermatologist (dermatologist not required for mild plaque psoriasis).

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For oral ulcers associated with Behcet's disease (initial requests): Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test. For psoriatic arthritis and plaque psoriasis (all requests): Will not be used in combination with biologic therapy for the prescribed indication.

**PART B PREREQUISITE**

N/A

## **PANRETIN\_NVT\_2025**

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### **MEDICATION(S)**

PANRETIN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## PART D VS PART B

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### MEDICATION(S)

ABELCET, ACETYL CYSTEINE 10 % SOLUTION, ACETYL CYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, APREPITANT, ARFORMOTEROL TARTRATE, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 50 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOSPORINE, CYCLOSPORINE MODIFIED 100 MG CAP, CYCLOSPORINE MODIFIED 25 MG CAP, CYCLOSPORINE MODIFIED 50 MG CAP, CYCLOSPORINE MODIFIED, DIPHTHERIA-TETANUS TOXOIDS DT, ENGERIX-B, ENVARUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN, GENGRAF, GRANisetron HCL 1 MG TAB, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IMOVAx RABIES, INSULIN ASPART, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, METHYL PREDNISOLONE 16 MG TAB, METHYL PREDNISOLONE 32 MG TAB, METHYL PREDNISOLONE 4 MG TAB, METHYL PREDNISOLONE 8 MG TAB, METHYL PREDNISOLONE 16 MG TAB, METHYL PREDNISOLONE 32 MG TAB, METHYL PREDNISOLONE 4 MG TAB, METHYL PREDNISOLONE 8 MG TAB, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NOVOLOG, NOVOLOG RELION, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLUTION, PLENAMINE, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 25 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 6.7 (5 BASE) MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 6.7 (5 BASE) MG/5ML SOLUTION, PREDNISONE 10 MG TAB, PREDNISONE 1 MG TAB, PREDNISONE 20 MG TAB, PREDNISONE 2.5 MG TAB, PREDNISONE 50 MG TAB, PREDNISONE 5 MG TAB, PREDNISONE 10 MG TAB, PREDNISONE 1

MG TAB, PREDNISONE 20 MG TAB, PREDNISONE 2.5 MG TAB, PREDNISONE 50 MG TAB, PREDNISONE 5 MG/5ML SOLUTION, PREDNISONE 5 MG TAB, PREDNISONE INTENSOL, PREHEVBRI, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PULMOZYME, RABAVERT, RECOMBIVAX HB, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 1 MG TAB, SIROLIMUS 2 MG TAB, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TDVAX, TENIVAC, TETANUS-DIPHTHERIA TOXOIDS TD

## **DETAILS**

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

## **PEGASYS\_(UCARE)\_2025**

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### **MEDICATION(S)**

PEGASYS

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **PEMAZYRE\_NVT\_2025**

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### **MEDICATION(S)**

PEMAZYRE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **PENICILLAMINE\_(UCARE)\_2025**

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### **MEDICATION(S)**

PENICILLAMINE 250 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For Wilson's Disease: Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **PHENYLBUTYRATE\_(UCARE)\_2025**

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### **MEDICATION(S)**

SODIUM PHENYLBUTYRATE 500 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

Concomitant use of other phenylbutyrate products (e.g., Ravicti, Buphenyl, Pheburane, Olpruva)

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)

### **COVERAGE DURATION**

Criteria met without genetic test: Approve for 3 months. Met with genetic test: Approve for 1 year.

### **OTHER CRITERIA**

For urea cycle disorders: Approve if genetic testing confirmed a mutation resulting in a urea cycle disorder OR if the member has hyperammonemia.

### **PART B PREREQUISITE**

N/A

## **PIQRAY\_NVT\_2025**

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### **MEDICATION(S)**

PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **POMALYST\_NVT\_2025**

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### **MEDICATION(S)**

POMALYST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **PREVYMIS\_NVT\_2025**

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### **MEDICATION(S)**

PREVYMIS 120 MG PACKET, PREVYMIS 240 MG TAB, PREVYMIS 480 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Member will/has initiated Prevymis within 30 days after an allogeneic hematopoietic stem cell transplant or 7 days after kidney transplant.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist.

### **COVERAGE DURATION**

Approved for 8 months for hematopoietic stem cell transplant or 8 months for kidney transplant.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **PROMACTA\_NVT\_2025**

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### **MEDICATION(S)**

ELTROMBOPAG OLAMINE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **QINLOCK\_NVT\_2025**

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### **MEDICATION(S)**

QINLOCK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **QUININE\_NVT\_2025**

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### **MEDICATION(S)**

QUININE SULFATE 324 MG CAP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for 1 month.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RADICAVA\_NVT\_2025**

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### **MEDICATION(S)**

RADICAVA ORS, RADICAVA ORS STARTER KIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: Member has a score of two or greater for each individual item on the Amyotrophic Lateral Sclerosis Functional Rating Scale-Revised (ALSFRS-R). For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RALDESY\_NVT\_2025**

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### **MEDICATION(S)**

RALDESY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Member is unable to swallow solid dosage forms of trazodone.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RETACRIT\_NVT\_2025**

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### **MEDICATION(S)**

RETACRIT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RETEVMO\_NVT\_2025**

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### **MEDICATION(S)**

RETEVMO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REVATIO\_NVT\_2025**

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### **MEDICATION(S)**

SILDENAFIL CITRATE 20 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REVLIMID\_NVT\_2025**

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### **MEDICATION(S)**

LENALIDOMIDE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REVUFORJ\_NVT\_2025**

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### **MEDICATION(S)**

REVUFORJ

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REZDIFFRA\_NVT\_2025**

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### **MEDICATION(S)**

REZDIFFRA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For noncirrhotic nonalcoholic steatohepatitis (initial requests): 1) Stage F2 or F3 fibrosis confirmed by one of the following: a) Liver biopsy or b) Both of the following: i) Fibrosis-4 score greater than or equal to 1.3 and ii) One of the following: Vibration-controlled transient elastography greater than or equal to 8 kPa, magnetic resonance elastography greater than or equal to 3.63 kPa, or enhanced liver fibrosis test greater than or equal to 7.7 and 2) Attestation that the medication will be used in conjunction with diet and exercise and 3) Member will abstain from alcohol consumption. For noncirrhotic nonalcoholic steatohepatitis (continuation requests): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a hepatologist or gastroenterologist

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REZLIDHIA\_NVT\_2025**

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### **MEDICATION(S)**

REZLIDHIA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **REZUROCK\_NVT\_2025**

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### **MEDICATION(S)**

REZUROCK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RILUZOLE\_(UCARE)\_2025**

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### **MEDICATION(S)**

RILUZOLE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis

### **AGE RESTRICTION**

N/A

### **PREScriber RESTRICTION**

Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of Amyotrophic Lateral Sclerosis (ALS).

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RINVOQ\_(UCARE)\_2025**

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### **MEDICATION(S)**

RINVOQ, RINVOQ LQ

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For ulcerative colitis (initial requests): Trial of a TNF antagonist was ineffective or not tolerated. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of other agents not required. For Crohn's disease (initial requests): Trial of Hadlima, adalimumab-aaty, or Simlandi was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For giant cell arteritis (initial requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, or giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For Crohn's disease or ulcerative colitis: Prescribed by, or in consultation with a

gastroenterologist.

## **COVERAGE DURATION**

Approved for duration of 1 year.

## **OTHER CRITERIA**

For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

## **PART B PREREQUISITE**

N/A

## **ROMVIMZA\_NVT\_2025**

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### **MEDICATION(S)**

ROMVIMZA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ROZLYTREK\_NVT\_2025**

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### **MEDICATION(S)**

ROZLYTREK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RUBRACA\_NVT\_2025**

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### **MEDICATION(S)**

RUBRACA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **RYDAPT\_NVT\_2025**

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### **MEDICATION(S)**

RYDAPT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SABRIL\_NVT\_2025**

---

### **MEDICATION(S)**

VIGABATRIN, VIGADRONE, VIGPODER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SCEMBLIX\_NVT\_2025**

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### **MEDICATION(S)**

SCEMBLIX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For T315I mutation: failure of or intolerance to Iclusig required.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SECUADO\_NVT\_2025**

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### **MEDICATION(S)**

SECUADO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, f) lurasidone, or g) oral asenapine.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SENSIPAR\_(UCARE)\_2025**

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### **MEDICATION(S)**

CINACALCET HCL

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Hyperparathyroidism in post-renal transplant patients

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Hypercalcemia due to parathyroid carcinoma: Prescribed by, or in consultation with, an oncologist or endocrinologist. Hypercalcemia with primary hyperparathyroidism: Prescribed by, or in consultation with, a nephrologist or endocrinologist. Hyperparathyroidism in post-renal transplant: Prescribed by, or in consultation with, a transplant physician, nephrologist or endocrinologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For hypercalcemia due to parathyroid carcinoma: Approve. For hypercalcemia in patients with primary hyperparathyroidism: Approve if the member has failed or is unable to undergo a parathyroidectomy due to a contraindication, as determined by the prescriber. For hyperparathyroidism in post-renal transplant patients: Approve if the baseline (prior to starting cinacalcet therapy) calcium and intact parathyroid hormone (iPTH) levels are above the normal range, as defined by the laboratory reference values. For secondary hyperparathyroidism in patients with chronic kidney disease on dialysis: Deny under Medicare Part D (claim should be submitted under the end stage renal disease (ESRD) bundle payment benefit).

**PART B PREREQUISITE**

N/A

## **SIGNIFOR\_NVT\_2025**

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### **MEDICATION(S)**

SIGNIFOR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SIMLANDI\_(UCARE)\_2025**

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### **MEDICATION(S)**

SIMLANDI (1 PEN), SIMLANDI (1 SYRINGE), SIMLANDI (2 PEN), SIMLANDI (2 SYRINGE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(all requests): Trial of other agents not required. For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate, mycophenolate mofetil, or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis, psoriatic arthritis, or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.

**COVERAGE DURATION**

Approved for duration of 1 year.

**OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **SKYRIZI\_NVT\_2025**

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### **MEDICATION(S)**

SKYRIZI 150 MG/ML SOLN PRSYR, SKYRIZI 180 MG/1.2ML SOLN CART, SKYRIZI 360 MG/2.4ML SOLN CART, SKYRIZI PEN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For psoriatic arthritis (all requests): Trial of other agents not required. For Crohn's disease (all requests): Trial of other agents not required. For ulcerative colitis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **SOLARAZE\_NVT\_2025**

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### **MEDICATION(S)**

DICLOFENAC SODIUM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SOMAVERT\_NVT\_2025**

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### **MEDICATION(S)**

SOMAVERT

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SPRYCEL\_NVT\_2025**

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### **MEDICATION(S)**

DASATINIB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **STELARA\_NVT\_2025**

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### **MEDICATION(S)**

STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 45 MG/0.5ML SOLUTION, STELARA 90 MG/ML SOLN PRSYR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **STEQEYMA\_(UCARE)\_2025**

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### **MEDICATION(S)**

STEQEYMA 90 MG/ML SOLN PRSYR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For psoriatic arthritis (all requests): Trial of other agents not required. For ulcerative colitis and Crohn's disease (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For psoriatic arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A



## **STIVARGA\_NVT\_2025**

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### **MEDICATION(S)**

STIVARGA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SUCRAID\_NVT\_2025**

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### **MEDICATION(S)**

SUCRAID

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SUNOSI\_NVT\_2025**

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### **MEDICATION(S)**

SUNOSI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

One of the following was ineffective or not tolerated: a) modafinil OR b) armodafinil.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

A nocturnal polysomnogram was used to confirm diagnosis.

### **PART B PREREQUISITE**

N/A

## **SUTENT\_NVT\_2025**

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### **MEDICATION(S)**

SUNITINIB MALATE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **SYPRINE\_NVT\_2025**

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### **MEDICATION(S)**

TRIENTINE HCL 250 MG CAP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TABRECTA\_NVT\_2025**

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### **MEDICATION(S)**

TABRECTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TAFINLAR\_NVT\_2025**

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### **MEDICATION(S)**

TAFINLAR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TAGRISSO\_NVT\_2025**

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### **MEDICATION(S)**

TAGRISSO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TALZENNA\_NVT\_2025**

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### **MEDICATION(S)**

TALZENNA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TARCEVA\_NVT\_2025**

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### **MEDICATION(S)**

ERLOTINIB HCL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TARGETIN\_NVT\_2025**

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### **MEDICATION(S)**

BEXAROTENE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TASIGNA\_NVT\_2025**

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### **MEDICATION(S)**

NILOTINIB HCL

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TAZORAC\_NVT\_2025**

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### **MEDICATION(S)**

TAZAROTENE 0.1 % CREAM

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TAZVERIK\_NVT\_2025**

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### **MEDICATION(S)**

TAZVERIK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TEPMETKO\_NVT\_2025**

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### **MEDICATION(S)**

TEPMETKO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TERIPARATIDE\_(UCARE)\_2025**

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### **MEDICATION(S)**

TERIPARATIDE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

Concomitant use with other medications for osteoporosis

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

High risk for fracture: 2 years. Not high risk for fracture: Max of 2 years therapy per lifetime.

### **OTHER CRITERIA**

For postmenopausal osteoporosis: Approve if the member has tried one oral bisphosphonate (e.g., alendronate and ibandronate) OR the member cannot take an oral bisphosphonate due to the inability to swallow or difficulty swallowing or the member cannot remain in an upright position following oral bisphosphonate administration or the member has a pre-existing gastrointestinal medical condition (e.g., esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR the member has tried an IV bisphosphonate (e.g., ibandronate or zoledronic acid), OR the member has severe renal impairment (creatinine clearance less than 35 mL/min), has chronic kidney disease or the member has had an osteoporotic fracture or fragility fracture. For increasing bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogonadal osteoporosis OR for the treatment of glucocorticoid induced osteoporosis: Approve if the member has

tried one oral bisphosphonate (e.g., alendronate and ibandronate) OR the member cannot take an oral bisphosphonate due to the inability to swallow or difficulty swallowing or the member cannot remain in an upright position following oral bisphosphonate administration or the member has a pre-existing gastrointestinal medical condition (e.g., esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR the member has tried zoledronic acid (Reclast), OR the member has severe renal impairment (CrCL less than 35 mL/min), has chronic kidney disease or the member has had an osteoporotic fracture or fragility fracture. Patients who have already taken teriparatide (Forteo) for 2 years: Approve if the member is at high risk for fracture.

## **PART B PREREQUISITE**

N/A

## **TESTOSTERONE\_NVT\_2025**

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### **MEDICATION(S)**

TESTOSTERONE 10 MG/ACT (2%) GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 1.62 % GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 30 MG/ACT SOLUTION, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL, TESTOSTERONE CYPIONATE 100 MG/ML SOLUTION, TESTOSTERONE CYPIONATE 200 MG/ML SOLUTION, TESTOSTERONE ENANTHATE 200 MG/ML SOLUTION

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

A) For initial requests: documentation is provided of morning testosterone levels, from two separate days, that fall below the normal range for a healthy adult male. B) For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TIBSOVO\_NVT\_2025**

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### **MEDICATION(S)**

TIBSOVO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TOBI\_NVT\_2025**

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### **MEDICATION(S)**

TOBRAMYCIN 300 MG/5ML NEBU SOLN

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

Approval will be based off BvD coverage determination.

### **PART B PREREQUISITE**

N/A

## **TRACLEER\_NVT\_2025**

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### **MEDICATION(S)**

BOSENTAN 125 MG TAB, BOSENTAN 62.5 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TRANSMUCOSAL\_FENTANYL\_(UCARE)\_2025**

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### **MEDICATION(S)**

FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG LOZ HANDLE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For breakthrough pain in patients with cancer: Approve if the member is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR the member is unable to take 2 other short-acting narcotics (e.g., oxycodone, morphine sulfate, hydromorphone) secondary to allergy or severe adverse events AND the member is on, or will be on a long-acting narcotic (e.g., fentanyl patches, morphine sulfate extended release), OR the member is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (e.g., morphine sulfate, hydromorphone, fentanyl citrate).

### **PART B PREREQUISITE**

N/A



## **TRIKAFTA\_NVT\_2025**

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### **MEDICATION(S)**

TRIKAFTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TRUQAP\_NVT\_2025**

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### **MEDICATION(S)**

TRUQAP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TUKYSA\_NVT\_2025**

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### **MEDICATION(S)**

TUKYSA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TURALIO\_NVT\_2025**

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### **MEDICATION(S)**

TURALIO 125 MG CAP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TYENNE\_(UCARE)\_2025**

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### **MEDICATION(S)**

TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Systemic sclerosis-associated interstitial lung disease

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Hadlima, adalimumab-aaty, or Simlandi, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi, b) Enbrel, c) Xeljanz, or d) Rinvoq. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For rheumatoid arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **TYKERB\_NVT\_2025**

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### **MEDICATION(S)**

LAPATINIB DITOSYLATE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **TYRVAYA\_(UCARE)\_2025**

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### **MEDICATION(S)**

TYRVAYA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For Dry Eye Disease: Trial of cyclosporine 0.05% eye emulsion was ineffective or not tolerated

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **UCERIS\_NVT\_2025**

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### **MEDICATION(S)**

BUDESONIDE 2 MG/ACT FOAM, BUDESONIDE 2 MG FOAM, BUDESONIDE ER

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of mesalamine was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **UPTRAVI\_(UCARE)\_2025**

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### **MEDICATION(S)**

UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VALCHLOR\_NVT\_2025**

---

### **MEDICATION(S)**

VALCHLOR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VANFLYTA\_NVT\_2025**

---

### **MEDICATION(S)**

VANFLYTA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VENCLEXTA\_NVT\_2025**

---

### **MEDICATION(S)**

VENCLEXTA, VENCLEXTA STARTING PACK

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VERZENIO\_NVT\_2025**

---

### **MEDICATION(S)**

VERZENIO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VIGAFYDE\_NVT\_2025**

---

### **MEDICATION(S)**

VIGAFYDE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Both of the following: A) Member is unable to swallow vigabatrin tablet and B) Member is unable to use vigabatrin powder for oral solution.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VITRAKVI\_NVT\_2025**

---

### **MEDICATION(S)**

VITRAKVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VIZIMPRO\_NVT\_2025**

---

### **MEDICATION(S)**

VIZIMPRO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VONJO\_NVT\_2025**

---

### **MEDICATION(S)**

VONJO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VOQUEZNA\_(UCARE)\_2025**

---

### **MEDICATION(S)**

VOQUEZNA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Trial of at least one generic proton pump inhibitor (PPI) medication was ineffective or not tolerated.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approval duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VORANIGO\_NVT\_2025**

---

### **MEDICATION(S)**

VORANIGO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VORICONAZOLE\_NVT\_2025**

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### **MEDICATION(S)**

VORICONAZOLE 200 MG TAB, VORICONAZOLE 50 MG TAB, VORICONAZOLE 200 MG RECON SOLN, VORICONAZOLE 40 MG/ML RECON SUSP

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for 6 months.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VOSEVI\_NVT\_2025**

---

### **MEDICATION(S)**

VOSEVI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

1) Current HCV-RNA titer is provided 3) Member does not have decompensated cirrhosis 3) Previous Hepatitis C treatment(s) is provided.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist.

### **COVERAGE DURATION**

Coverage duration of 12 weeks.

### **OTHER CRITERIA**

Treatment regimen will be approved based on previous treatment experience as defined by current AASLD guidelines.

### **PART B PREREQUISITE**

N/A

## **VOTRIENT\_NVT\_2025**

---

### **MEDICATION(S)**

PAZOPANIB HCL 200 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **VOWST\_NVT\_2025**

---

### **MEDICATION(S)**

VOWST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for 1 month.

### **OTHER CRITERIA**

For all requests: Will not be used in combination with fecal microbiota, live for rectal use (Rebyota) or bezlotoxumab (Zinplava).

### **PART B PREREQUISITE**

N/A

## **VYNDAMAX\_NVT\_2025**

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### **MEDICATION(S)**

VYNDAMAX

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For Initial requests: Diagnosis confirmed by one of the following: A) Cardiac biopsy with positive congo red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining OR B) All of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 AND ii) Absence of monoclonal protein via serum protein immunofixation AND iii) Absence of monoclonal protein via urine protein immunofixation AND iv) Myocardial uptake of 99mTc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. For continuation requests: Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For all requests: Will not be used in combination with Tegsedi, Onpattro, or Amvuttra.

### **PART B PREREQUISITE**

N/A



## **WELIREG\_NVT\_2025**

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### **MEDICATION(S)**

WELIREG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **WINREVAIR\_NVT\_2025**

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### **MEDICATION(S)**

WINREVAIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Diagnosis confirmed by right heart catheterization.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **WYOST\_NVT\_2025**

---

### **MEDICATION(S)**

WYOST

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XALKORI\_NVT\_2025**

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### **MEDICATION(S)**

XALKORI

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XCOPRI\_NVT\_2025**

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### **MEDICATION(S)**

XCOPRI, XCOPRI (250 MG DAILY DOSE), XCOPRI (350 MG DAILY DOSE)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Two of the following were ineffective or not tolerated: a) lamotrigine b) carbamazepine c) levetiracetam d) oxcarbazepine e) phenytoin f) topiramate OR g) lacosamide.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XDEMVY\_(UCARE)\_2025**

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### **MEDICATION(S)**

XDEMVY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

Demodex blepharitis: Prescribed by or in consultation with an optometrist or ophthalmologist

### **COVERAGE DURATION**

Approved for duration of 6 weeks.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XELJANZ\_(UCARE)\_2025**

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### **MEDICATION(S)**

XELJANZ, XELJANZ XR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For rheumatoid arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima, adalimumab-aaty, or Simlandi OR b) Enbrel. For ulcerative colitis (initial requests): Failure of, or intolerance to a TNF antagonist. For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

For rheumatoid arthritis, ankylosing spondylitis, or psoriatic arthritis: Prescribed by, or in consultation with a rheumatology specialist. For ulcerative colitis: Prescribed by, or in consultation with a gastroenterologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

**PART B PREREQUISITE**

N/A

## **XERMELO\_NVT\_2025**

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### **MEDICATION(S)**

XERMELO

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XIFAXAN 550MG\_NVT\_2025**

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### **MEDICATION(S)**

XIFAXAN 550 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For diagnosis of IBS-D, approval will increase quantity limit to 42 tablets over 14 days, maximum of three fills per 1 year.

### **PART B PREREQUISITE**

N/A

## **XOLAIR\_NVT\_2025**

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### **MEDICATION(S)**

XOLAIR

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For initial requests: For asthma: History within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For chronic idiopathic urticaria: one of the following: a) patient remains symptomatic despite H1 antihistamine treatment OR b) has intolerance or contraindication to H1 antihistamine treatment. For nasal polyps: A) Confirmed diagnosis of nasal polyps (see other criteria) AND B) One of the following was ineffective or not tolerated: a) Dupixent or b) Nucala. For IgE-mediated food allergy: Confirmed diagnosis of IgE-mediated food allergy (see other criteria). For continuation requests (all diagnoses): Member has benefited with use of this medication.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

For asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic idiopathic urticaria: Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For IgE-mediated food allergy: Prescribed by, or in consultation with an allergist or immunologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

## **OTHER CRITERIA**

For asthma (initial requests): Documentation of diagnosis via skin test or RAST for specific allergy sensitivity. For nasal polyps (initial requests): Diagnosis is confirmed with a sinus CT scan AND at least four of the following apply: a) prior surgery for bilateral nasal polyposis b) evidence of type 2 inflammation c) two or more courses of oral corticosteroids required in the prior year d) significantly impaired quality of life e) significant loss of smell f) diagnosis of comorbid asthma. For IgE-mediated food allergy (initial requests): Both of the following: a) diagnosis supported by one of the following: i) positive skin prick test or ii) positive serum IgE test and b) diagnosis confirmed by one of the following: i) positive oral food challenge or ii) history of anaphylaxis to the suspected food allergen. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. For IgE-mediated food allergy (all requests): Will not be used in combination with peanut allergen powder (Palforzia).

## **PART B PREREQUISITE**

N/A

## **XOSPATA\_NVT\_2025**

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### **MEDICATION(S)**

XOSPATA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XPOVIO\_NVT\_2025**

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### **MEDICATION(S)**

XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK, XPOVIO (40 MG ONCE WEEKLY) 10 MG TAB THPK, XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK, XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK, XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK, XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK, XPOVIO (80 MG TWICE WEEKLY)

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XTANDI\_NVT\_2025**

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### **MEDICATION(S)**

XTANDI

### **PA INDICATION INDICATOR**

4 - All FDA-Approved Indications, Some Medically-Accepted Indications

### **OFF LABEL USES**

Homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna.

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For metastatic castration-resistant prostate cancer and metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Both of the following were ineffective or not tolerated: a) Nubeqa and b) Erleada. For non metastatic castration sensitive prostate cancer with biochemical recurrence at high risk for metastasis: Trial of other agents not required. For homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer in combination with Talzenna: Trial of other agents not required.

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **XYREM\_NVT\_2025**

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### **MEDICATION(S)**

SODIUM OXYBATE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. Trial of other agents not required for patients aged 7 to 17 years. For cataplexy with narcolepsy: Trial of other agents not required.

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

For excessive daytime sleepiness with narcolepsy: A nocturnal polysomnogram was used to confirm diagnosis. For cataplexy with narcolepsy: One of the following was used to confirm diagnosis: a) nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

### **PART B PREREQUISITE**

N/A

## **ZEJULA\_NVT\_2025**

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### **MEDICATION(S)**

ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZELBORAF\_NVT\_2025**

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### **MEDICATION(S)**

ZELBORAF

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZOLINZA\_NVT\_2025**

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### **MEDICATION(S)**

ZOLINZA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZTALMY\_NVT\_2025**

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### **MEDICATION(S)**

ZTALMY

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

Documentation is provided of a CDKL5 gene mutation

### **AGE RESTRICTION**

N/A

### **PRESCRIBER RESTRICTION**

Prescribed by, or in consultation with, a neurologist.

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZURZUVAE\_NVT\_2025**

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### **MEDICATION(S)**

ZURZUVAE

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for 1 month.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZYDELIG\_NVT\_2025**

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### **MEDICATION(S)**

ZYDELIG

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A

## **ZYKADIA\_NVT\_2025**

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### **MEDICATION(S)**

ZYKADIA

### **PA INDICATION INDICATOR**

1 - All FDA-Approved Indications

### **OFF LABEL USES**

N/A

### **EXCLUSION CRITERIA**

N/A

### **REQUIRED MEDICAL INFORMATION**

N/A

### **AGE RESTRICTION**

N/A

### **PREScriBER RESTRICTION**

N/A

### **COVERAGE DURATION**

Approved for duration of 1 year.

### **OTHER CRITERIA**

N/A

### **PART B PREREQUISITE**

N/A