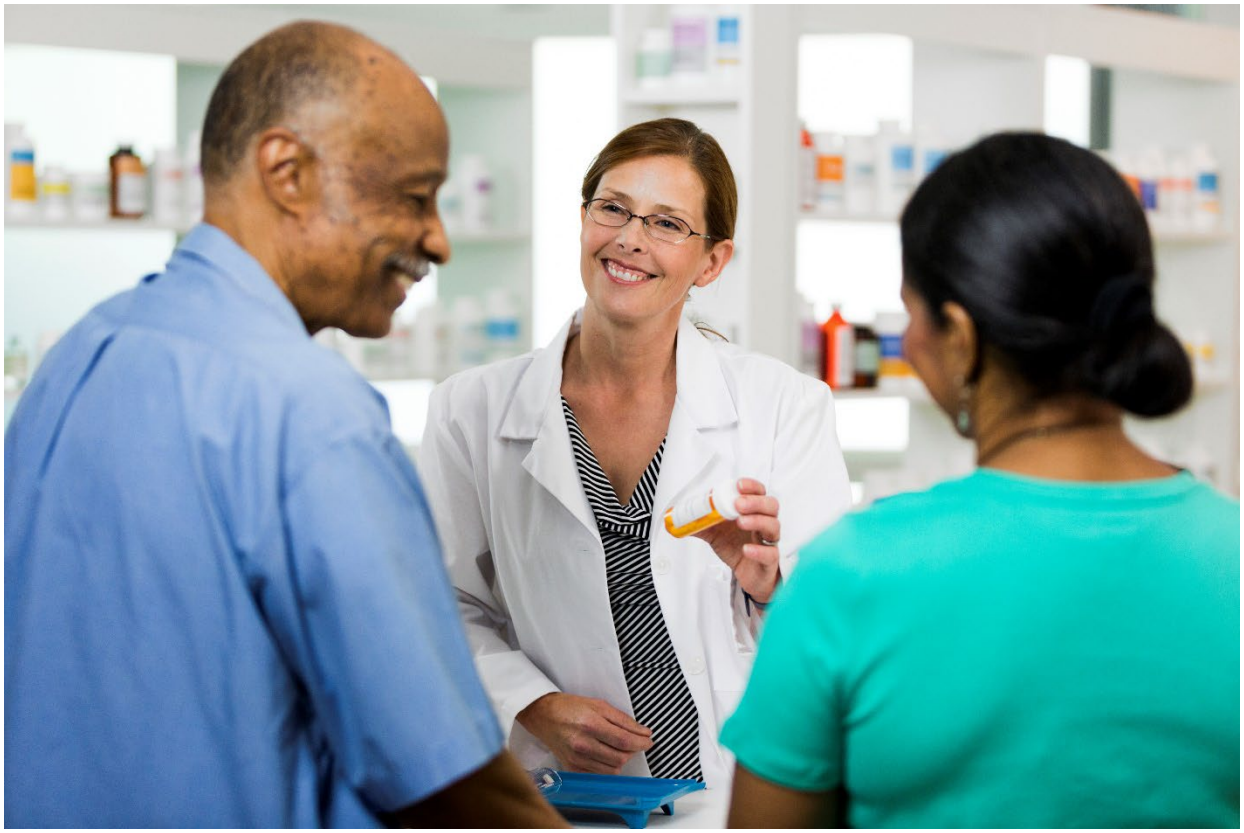

2025 PRIOR AUTHORIZATION CRITERIA

Essential Rx (PPO)

Aspirus Health Plan 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, Aspirus Health Plan may not cover the drug.

Last updated: 11/01/2025

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan 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 **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (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 **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus Health Plan 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 Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715-631-7439

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 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

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 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ለተሳናቸው: 715-631-7413/1-855-931-4852).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសវាជំនួយរ៉ែផ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរ៉ើអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY715-631-7413/1-855-931-4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715-631-7411/1-855-931-4850 (رقم هاتف الصم والبكم: 715-631-7413/1-855-931-4852.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ABIRATERONE

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

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

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

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

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

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

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

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 2.5 MG TAB, 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

AKEEGA

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

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

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

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

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

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

AUGTYRO

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

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

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

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

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

MEDICATION(S)
RUFINAMIDE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 members 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

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

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

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

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

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

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

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

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

DEMSER

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

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

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

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 (BPDAI) 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

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

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

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

EPCLUSA

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

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

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

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

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

FANAPT

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

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

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

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

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

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

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

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

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

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

MEDICATION(S)
BYDUREON BCISE, LIRAGLUTIDE, 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

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

MEDICATION(S)
OMNITROPE, SKYTROFA 11 MG CARTRIDGE, SKYTROFA 13.3 MG CARTRIDGE, SKYTROFA 3 MG CARTRIDGE, SKYTROFA 3.6 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

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

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

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

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

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, CLORAZEPATE DIPOTASSIUM, DIAZEPAM 10 MG TAB, DIAZEPAM 2 MG TAB, DIAZEPAM 5 MG TAB, DIAZEPAM 5 MG/5ML SOLUTION, DIAZEPAM 5 MG/ML CONC, DIAZEPAM INTENSOL, LORAZEPAM 0.5 MG TAB, LORAZEPAM 1 MG TAB, LORAZEPAM 2 MG TAB, LORAZEPAM 2 MG/ML CONC, 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

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

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

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

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

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 is 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-PDGFRA, or c) PDGFRB rearrangement.

PART B PREREQUISITE

N/A

IMBRUVICA

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

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

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

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

INLYTA

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

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

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

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

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

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION, ITRACONAZOLE 100 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 a duration of 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IVIG

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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, 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

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

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

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

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

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

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

MEDICATION(S)
MEGESTROL ACETATE 40 MG/ML SUSPENSION, MEGESTROL ACETATE 400 MG/10ML 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

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

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

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

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

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

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

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis. For Avonex, Kesimpta, and Plegridy, 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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICATION(S)
OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 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

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

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

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

OJEMDA

MEDICATION(S)
OJEMDA

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

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

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

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

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

ORGOVYX

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

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

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

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

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

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, 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, AMPHOTERICIN B 50 MG RECON SOLN, APREPITANT, ARFORMOTEROL TARTRATE, 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 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, DIPHTHERIA-TETANUS TOXOIDS DT, ENGERIX-B, ENVARSUS 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 BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, 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, METHYLPREDNISOLONE 16 MG TAB, METHYLPREDNISOLONE 32 MG TAB, METHYLPREDNISOLONE 4 MG TAB, METHYLPREDNISOLONE 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 TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLUTION, PLENAMINE, 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, PREDNISONE 1 MG TAB, PREDNISONE 10 MG TAB, PREDNISONE 2.5 MG TAB, PREDNISONE 20 MG TAB, PREDNISONE 5 MG TAB, PREDNISONE 5 MG/5ML SOLUTION, PREDNISONE 50 MG TAB, PREDNISONE INTENSOL, PREHEVBRIO, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PULMOZYME, RABAVERT, RECOMBIVAX HB, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TARGRETIN

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

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

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

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

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

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

MEDICATION(S)
TESTOSTERONE 1.62 % GEL, TESTOSTERONE 10 MG/ACT (2%) 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 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

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

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

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

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

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

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

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

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

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

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

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

MEDICATION(S)
BUDESONIDE 2 MG FOAM, BUDESONIDE 2 MG/ACT 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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICATION(S)
PAZOPANIB 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

VOWST

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

WELIREG

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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