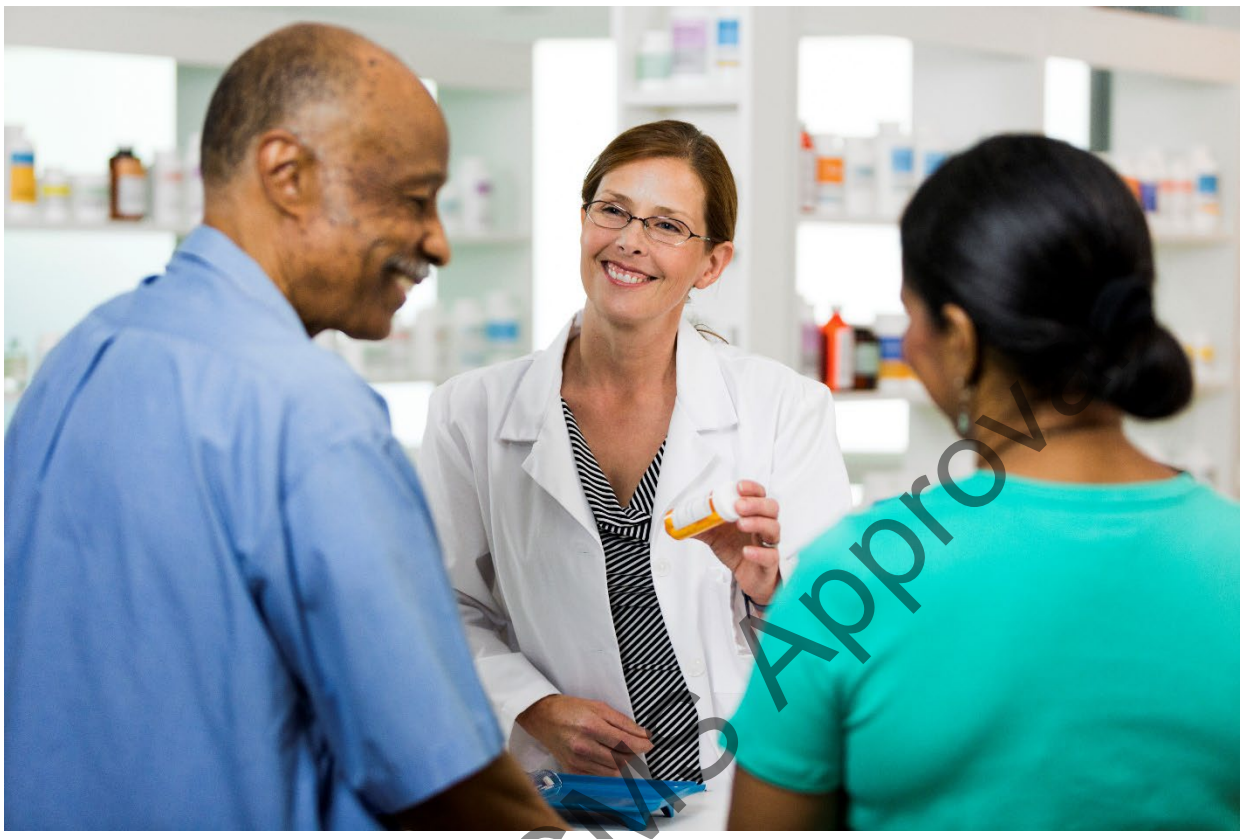

2026 PRIOR AUTHORIZATION CRITERIA

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: 01/01/2026

Notice of Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ልብ ይበሉ:- የአማርኛ ቋንቋ የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎት ለእርስዎ ቀርቦልዎታል። ተደራሽ በሆኑ ቅርፀቶች መረጃዎችን ለማቅረብ ተገቢ የሆኑ አጋዥ ድጋፍ ሰጪ መሳሪያዎች እና አገልግሎቶችም እንዲሁ በነፃ ቀርበዋል። በ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) ይደውሉ.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. يمكنك الاتصال على الرقم 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

សូមជ្រាបជាដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាកម្មជំនួយភាសាតតគិតថ្លៃអាចត្រូវបានផ្តល់ជូនសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏ត្រូវបានផ្តល់ជូន ដោយតតគិតថ្លៃផងដែរ។ ទូរសព្ទទៅលេខ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) ។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 715.631.7411/1.855.931.4850 (聽障專線: 715.631.7413/1.855.931.4852)。

请注意：如果您说普通话，我们可为您免费提供语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852)。

ATTENTION : Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS : 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 715.631.7411/ 1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपकेललए नन: शुल्क भाषा सहायता सेवाएंउपलब्ध हैं। सुलभ फॉर्मेट मेंजानकारी प्रदान करनेकेललए उपयुक्त सहायक साधन और सेवाएंभी नन: शुल्क उपलब्ध हैं। 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາແມ່ນພ້ອມໃຫ້ບໍລິການແກ່ທ່ານ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ຟຣີອີກນຳ. ໂທ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

HUBACHIISA: Afaan Oromo kan dubbattan yoo ta'e, tajaajila gargaarsa afaanii bilisaan ni argattu. Odeeffannoo bifa dhaqqabamaa ta’een dhiheessuf, gargaarsii fi tajaajiloomni dabalataa mijatoo ta’anis bilisaan ni kennamu. Bilbilaa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa laguu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si macluumaadka laguugu siiyo qaabab la isticmaali karo ayaa sidoo kale laguu heli karaa weliba si lacag la'aan ah. Wac 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ACNE AGENTS

MEDICATION(S)
TRETINOIN CREAM (0.025 %, 0.05 %, 0.1 %)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

ADBRY

MEDICATION(S)
ADBRY

PA INDICATION INDICATOR
N/A

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 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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

ADEMPAS

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension: Both of the following were ineffective or not tolerated: one endothelial receptor antagonist (ambrisentan, bosentan or macitentan (Opsumit)) and one phosphodiesterase-5 inhibitor (sildenafil or tadalafil). For persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4): 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

PREREQUISITE THERAPY REQUIRED
YES

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AIMOVIG

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For migraine prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. For migraine prevention (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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

ALPHA1

MEDICATION(S)
PROLASTIN-C 1000 MG/20ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Both of the following: 1) Diagnosis of congenital alpha1-antitrypsin deficiency is confirmed by both of the following: A) circulating baseline alpha1-antitrysin level is below the standard protective threshold (less than 11 micromol/L or less than 50 mg per deciliter by nephelometry) and B) high risk alpha1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) and 2) Prescriber attests that member does not have IgA deficiency with known anti-IgA antibody.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION 12 & 18 & 24 & 30 MG TBER THPK

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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

BANZEL

MEDICATION(S)
RUFINAMIDE

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

BENLYSTA

MEDICATION(S)
BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

BESREMI

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For polycythemia vera: One of the following: A) Both of the following: i) High risk disease as defined by one of the following: a) Age 60 years or older or b) History of thrombosis and ii) Trial of hydroxyurea was ineffective, contraindicated, or not tolerated or B) Both of the following: i) Low risk as defined by both of the following: a) Age less than 60 years and b) No history of thrombosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

CALQUENCE

MEDICATION(S)
CALQUENCE 100 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

PREREQUISITE THERAPY REQUIRED
N/A

CAPLYTA

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

COBENFY

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
N/A

CONTINUOUS GLUCOSE MONITORS

MEDICATION(S)
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 3 PLUS SENSOR, FREESTYLE LIBRE 3 READER, 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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

CRESEMBA

MEDICATION(S)
CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
For invasive aspergillosis: 3 months. For invasive mucormycosis: 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTADROPS

MEDICATION(S)
CYSTADROPS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

DIACOMIT

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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 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 (trial of other agents not required for patients under 2 years of age). For asthma (initial requests): History within the last year of at least one 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 (initial requests): Trial of a nasal corticosteroid was ineffective or not tolerated. For eosinophilic esophagitis (initial requests): Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis (initial requests): Trial of other agents not required. For chronic obstructive pulmonary disease (COPD)(initial requests): History, within the last year, of at least one severe or two moderate COPD exacerbations despite receiving optimized (triple therapy) maintenance therapy. For chronic spontaneous urticaria (initial requests): One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For atopic dermatitis, prurigo nodularis, or chronic spontaneous urticaria: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For asthma or COPD: Prescribed by, or in consultation with, an allergist, pulmonologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis:

Prescribed by, or in consultation with, an allergist or 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 of the following: a) Intractable pruritus (itching), b) Cracking and oozing/bleeding of skin or c) Impaired activities of daily living. For asthma (initial requests): 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. For nasal polyps (initial requests): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis (initial requests): Both of the following: 1) Endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) and 2) Symptoms of esophageal dysfunction (e.g. dysphagia). 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 COPD (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 300 cells/microliter. For all atopic dermatitis, asthma, prurigo nodularis, or COPD (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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 prevention (initial requests): Member has 4 or more migraine days per month for the previous 3 months or longer. 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

PREREQUISITE THERAPY REQUIRED
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
N/A

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 polyarticular juvenile idiopathic arthritis (pJIA)(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, pJIA 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

PREREQUISITE THERAPY REQUIRED

YES

ENDARI

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initial requests: One of the following: 1) Both of the following: A) Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated and B) Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable) or 2) 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

PREREQUISITE THERAPY REQUIRED
YES

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
All of the following: 1) Current HCV-RNA titer is provided, 2) 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

PREREQUISITE THERAPY REQUIRED
N/A

EPIDIOLEX

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
N/A

ERLEADA

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP. For idiopathic pulmonary fibrosis (continuation requests): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For idiopathic pulmonary fibrosis: Prescribed by, or in consultation with, a pulmonologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For idiopathic pulmonary fibrosis (all requests): Will not be used in combination with other agents for the prescribed indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

EUCRISA

MEDICATION(S)
EUCRISA

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For atopic dermatitis: One of the following was ineffective or not tolerated: a) A topical corticosteroid or b) A topical calcineurin inhibitor

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FANAPT

MEDICATION(S)
FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

FASENRA

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For asthma (initial requests): History within the last year of at least one 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 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

PREREQUISITE THERAPY REQUIRED

YES

FINTEPLA

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

FYCOMPA

MEDICATION(S)
FYCOMPA 0.5 MG/ML SUSPENSION, PERAMPANEL

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

GLP-1_AGONISTS

MEDICATION(S)
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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
Prescribed by, or in consultation with, an endocrinologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HADLIMA

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PA INDICATION INDICATOR
N/A

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 polyarticular juvenile idiopathic arthritis (pJIA)(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 (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 ulcerative colitis (all requests): Trial of other agents not required. For 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, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or 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

PREREQUISITE THERAPY REQUIRED
YES

HAE AGENTS

MEDICATION(S)
HAEGARDA, ICATIBANT ACETATE

PA INDICATION INDICATOR
1 - 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 allergist or immunologist

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

PREREQUISITE THERAPY REQUIRED
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
All of the following: 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, and 4) 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

IMBRUVICA

MEDICATION(S)
IMBRUVICA 140 MG CAP, IMBRUVICA 140 MG TAB, IMBRUVICA 280 MG TAB, 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

PREREQUISITE THERAPY REQUIRED
N/A

IMKELDI

MEDICATION(S)
IMKELDI

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

IMPAVIDO

MEDICATION(S)
IMPAVIDO

PA INDICATION INDICATOR
N/A

OFF LABEL 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

INREBIC

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

ITRACONAZOLE

MEDICATION(S)
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

PREREQUISITE THERAPY REQUIRED
N/A

IVIG

MEDICATION(S)
GAMMAGARD, GAMMAGARD S/D LESS IGA, 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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 requests: 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

LIDOCAINE_PATCH

MEDICATION(S)
LIDOCAINE 5% PATCH

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

LONG_ACTING_OPIOIDS

MEDICATION(S)
BUPRENORPHINE WEEKLY PATCH, 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 10MG/5ML SOLUTION, METHADONE HCL 5MG/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
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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
All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) For prior treatment with a sofosbuvir-based regimen, 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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
For acute treatment of migraine: Trial of two different triptans was ineffective or not tolerated. Trial of triptans not required for patients with history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorders. Trial of second triptan not required for patients who did not tolerate initial triptan therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NEMLUVIO

MEDICATION(S)
NEMLUVIO

PA INDICATION INDICATOR
N/A

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 or prurigo nodularis: 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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

NEXLETOL

MEDICATION(S)
NEXLETOL, NEXLIZET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

NUBEQA

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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: 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
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

OFEV

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For idiopathic pulmonary fibrosis (initial requests): Both of the following: 1) Diagnosis confirmed by one of the following: A) Surgical lung biopsy or transbronchial lung cryobiopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP), B) High-resolution computed tomography (HRCT) indicates definite UIP pattern C) Both of the following: HRCT indicates possible UIP pattern and surgical lung biopsy or transbronchial lung cryobiopsy reveals a histopathological pattern of probable UIP and 2) Trial of pirfenidone was ineffective or not tolerated. For systemic sclerosis-associated interstitial lung disease (ILD) (initial requests): All of the following: 1) Diagnosis confirmed with documentation provided of both of the following: A) HRCT scan and B) pulmonary function tests, 2) Trial of mycophenolate mofetil was ineffective or not tolerated and 3) Trial of Tyenne was ineffective or not tolerated. For chronic fibrosing ILDs with a progressive phenotype (initial requests): All of the following: 1) Disease is progressive, as defined by one of the following over the past 12 months, with no alternative explanation: A) Worsening respiratory symptoms, B) One of the following: i) Forced vital capacity (FVC) decline of 5% or more or ii) Absolute decline in, and diffusing capacity of, the lung for carbon monoxide (corrected for hemoglobin) of 10% predicted or greater or C) Radiological evidence of disease progression and 2) 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, or vii) rituximab. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

For idiopathic pulmonary fibrosis and chronic fibrosing ILDs with a progressive phenotype: Prescribed by, or in consultation with, a pulmonologist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist or rheumatologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For idiopathic pulmonary fibrosis (all requests): Will not be used in combination with other agents for the prescribed indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

OPIPZA

MEDICATION(S)
OPIPZA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

OTEZLA

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

PART D VS PART B

MEDICATION(S)

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, AMPHOTERICIN B LIPOSOME, 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, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IMOVAX RABIES, INSULIN ASPART, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, JYNNEOS, 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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
Approved for duration of 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

RALDESY

MEDICATION(S)
RALDESY

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
N/A

RETEVMO

MEDICATION(S)
RETEVMO 120 MG TAB, RETEVMO 160 MG TAB, RETEVMO 40 MG TAB, RETEVMO 80 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For adenosine deaminase severe combined immune deficiency (ADA-SCID)(initial requests): Diagnosis confirmed by one of the following: a) Absent or very low (less than 1 percent of normal) ADA activity in red blood cells, b) Increased levels of deoxyadenosine triphosphate in erythrocyte lysates compared to laboratory standards, c) Significantly decreased concentration of adenosine triphosphate in red blood cells, d) Absent or very low (less than 5 percent of normal) levels of s-adenosylhomocysteine hydrolase in red blood cells, e) Elevated levels of 2-deoxyadensoine in plasma, urine, or dried blood spots, or f) Presence of biallelic pathogenic mutations in the ADA gene. For ADA-SCID (continuation requests): Member has benefited with use of this medication.

AGE RESTRICTION
Elevated levels of 2-deoxyadensoine in plasma, urine, or dried blood spots, or f) Presence of biallelic pathogenic mutations in the ADA gene. For ADA-SCID (continuation requests): Member has benefited with use of this medication.

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, an immunologist or provider who specializes ADA-SCID.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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. 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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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 or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima 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 or Simlandi or b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For Crohn’s disease (initial requests): Trial of Hadlima or Simlandi was ineffective or not tolerated. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima 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, pJIA, 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 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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

SABRIL

MEDICATION(S)
VIGABATRIN, 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

PREREQUISITE THERAPY REQUIRED
N/A

SCEMBLIX

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

SECUADO

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
N/A

SIMLANDI

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

PA INDICATION INDICATOR
N/A

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 polyarticular juvenile idiopathic arthritis (pJIA)(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 (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 ulcerative colitis (all requests): Trial of other agents not required. For 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, pJIA or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis or 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

PREREQUISITE THERAPY REQUIRED
YES

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
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

STELARA

MEDICATION(S)
STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 45 MG/0.5ML SOLUTION, STELARA 90 MG/ML SOLN PRSYR, USTEKINUMAB 45 MG/0.5ML SOLN PRSYR, USTEKINUMAB 45 MG/0.5ML SOLUTION, USTEKINUMAB 90 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
N/A

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 (all requests): Trial of other agents not required. For 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

PREREQUISITE THERAPY REQUIRED

YES

STEQEYMA

MEDICATION(S)
STEQEYMA 90 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
N/A

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 (all requests): Trial of other agents not required. For 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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

SUNOSI

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

TERIPARATIDE

MEDICATION(S)
TERIPARATIDE

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

TESTOSTERONE

MEDICATION(S)
TESTOSTERONE 1.62 % GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 30 MG/ACT SOLUTION, 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
For initial requests (all diagnoses): A) Attestation that hypogonadism is not age-related and B) Documentation is provided of two morning fasting testosterone levels (from two separate days) that fall below the normal range for a healthy adult male. 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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

TOLVAPTAN

MEDICATION(S)
TOLVAPTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Member has an eGFR of 25 ml/min/1.73m2 or greater (does not apply to generic Samsca equivalent).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a nephrologist (does not apply to generic Samsca equivalent).

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

TYENNE

MEDICATION(S)
TYENNE 162 MG/0.9ML SOLN A-INJ, TYENNE 162 MG/0.9ML SOLN PRSYR

PA INDICATION INDICATOR
N/A

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 or Simlandi, c) Rinvoq or d) Xeljanz. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): Two of the following were ineffective or not tolerated: a) Hadlima or Simlandi, b) Enbrel, c) Xeljanz, or d) Rinvoq. For giant cell arteritis (all requests): Trial of Rinvoq was ineffective or not tolerated. For systemic sclerosis-associated interstitial lung disease (initial requests): Both of the following: 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, pJIA, systemic juvenile idiopathic arthritis, or 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 or rheumatologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

TYRVAYA

MEDICATION(S)
TYRVAYA

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

UCERIS

MEDICATION(S)
BUDESONIDE ER 9 MG

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

VIGAFYDE

MEDICATION(S)
VIGAFYDE

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

VONJO

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Two of the following were ineffective or not tolerated: a) Jakafi, b) Inrebic, or c) Ojjaara.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOQUEZNA

MEDICATION(S)
VOQUEZNA

PA INDICATION INDICATOR
N/A

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
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

VOSEVI

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All of the following: 1) Current HCV-RNA titer is provided, 2) Member does not have decompensated cirrhosis, and 3) Previous hepatitis C treatments are provided.

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 weeks.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

WELIREG_NVT_2026

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

XCOPRI

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

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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
For 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

PREREQUISITE THERAPY REQUIRED
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 or Simlandi or b) Enbrel. For polyarticular juvenile idiopathic arthritis (pJIA)(initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Hadlima or Simlandi or b) Enbrel. For ulcerative colitis (initial requests): Trial of a TNF antagonist was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For rheumatoid arthritis, pJIA, 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

PREREQUISITE THERAPY REQUIRED

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

XOLAIR

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For asthma (initial requests): History within the last year of at least one 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 spontaneous urticaria (initial requests): Both of the following: 1) One of the following: a) Patient remains symptomatic despite H1 antihistamine treatment or b) Has intolerance or contraindication to H1 antihistamine treatment and 2) Trial of Dupixent was ineffective or not tolerated. For nasal polyps (initial requests): Dupixent was ineffective or not tolerated. For IgE-mediated food allergy (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 asthma: Prescribed by, or in consultation with an allergist, pulmonologist, or immunologist. For chronic spontaneous 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): All of the following: a) Diagnosis of chronic rhinosinusitis with nasal polyposis, lasting at least 12 weeks, b) Bilateral nasal polyposis confirmed with sinus CT scan, and c) Moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). 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

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

XTANDI

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED

YES

XYREM

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
N/A

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

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A