people powered health plans

2024 PRIOR AUTHORIZATION CRITERIA

UCare Connect + Medicare (SNBC) (HMO D-SNP)
UCare's Minnesota Senior Health Options (MSHO) (HMO D-SNP)

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

UCare's MSHO and UCare Connect + Medicare (HMO D-SNP) are health plans that contract with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare's MSHO and UCare Connect + Medicare depends on contract renewal.

Effective: 12/01/2024

H5937_5248_072022_C_19
H2456_5248_072022 accepted

U5248 12/2024

Toll free 1-800-203-7225, TTY 1-800-688-2534

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ့ၢ်လၢထးအံၤနူဉ်တကွၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll Free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

ABIRATERONE_(UCARE)_2024

MEDICATION(S)
ABIRATERONE ACETATE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

ii. Patient has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-very-high-risk-group-approve if according to the prescriber the patient is in the very-high-risk group, the medication will be used in combination with external beam radiation therapy and the patient meets one of the following criteria (i, ii or iii): i. abiraterone is used in combination with GnRH agonist OR ii. Patient has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-radical prostatectomy-approve if the medication is used in combination with prednisone, the patient has prostate specific antigen (PSA) persistence or recurrence following radical prostatectomy, patient has pelvic recurrence, the medication will be used concurrently with GnRH agonist, Firmagon or the patient has had a bilateral orchiectomy.

PART B PREREQUISITE

N/A

MEDICATION(S)
ACTEMRA 162 MG/0.9ML SOLN PRSYR, ACTEMRA ACTPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

ACTIMMUNE_NVT_2024

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ADALIMUMAB-AATY_(UCARE)_2024

MEDICATION(S)
ADALIMUMAB-AATY (1 PEN), ADALIMUMAB-AATY (2 PEN), ADALIMUMAB-AATY (2 SYRINGE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

consult with, a rheumatology specialist OR ophthalmologist.

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

MEDICATION(S)
ADBRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

ADCIRCA_NVT_2024

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

ADEMPAS_NVT_2024

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

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 ERA (ambrisentan, bosentan or macitentan (Opsumit)) AND one PDE5-inhibitor (sildenafil or tadalafil). C) 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

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB, EVEROLIMUS 5 MG TAB SOL, EVEROLIMUS 7.5 MG TAB, TORPENZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AIMOVIG_NVT_2024

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AJOVY_NVT_2024

MEDICATION(S)
AJOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Both of the following were ineffective or not tolerated: a) Aimovig AND b) Emgality. For initial requests: Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AKEEGA_NVT_2024

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALECENSA_NVT_2024

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ALK-positive disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALUNBRIG_NVT_2024

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ALK-positive disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ARCALYST_NVT_2024

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

AUGTYRO_NVT_2024

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of showing one of the following a) ROS1-positive disease. or b) NTRK gene fusion mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AUSTEDO_NVT_2024

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AYVAKIT_NVT_2024

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For unresectable or metastatic gastrointestinal stromal tumor: Documentation is provided of PDGFRA exon 18 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BALVERSA_NVT_2024

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of susceptible FGFR3 genetic alteration.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BANZEL_NVT_2024

MEDICATION(S)
RUFINAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BENLYSTA_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

BESREMI_NVT_2024

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BOSULIF_NVT_2024

MEDICATION(S)
BOSULIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRAFTOVI_NVT_2024

MEDICATION(S)
BRAFTOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate BRAF V600E or V600K mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRONCHITOL_NVT_2024

MEDICATION(S)
BRONCHITOL, BRONCHITOL TOLERANCE TEST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRUKINSA_NVT_2024

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CABOMETYX_NVT_2024

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CALQUENCE_NVT_2024

MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAPLYTA_NVT_2024

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For bipolar depression: Both of the following were ineffective or not tolerated: a) lurasidone AND b) quetiapine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAPRELSA_NVT_2024

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CARBAGLU_NVT_2024

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAYSTON_NVT_2024

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

CERDELGA_NVT_2024

MEDICATION(S)
CERDELGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/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 all requests: Will not be used in combination with imiglucerase (Cerezyme)

PART B PREREQUISITE
N/A

COMETRIQ_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CONTINUOUS GLUCOSE MONITORS_UCARE_2024

MEDICATION(S)
DEXCOM G5 MOB/G4 PLAT SENSOR, DEXCOM G5 MOBILE RECEIVER, DEXCOM G5 MOBILE TRANSMITTER, DEXCOM G5 RECEIVER KIT, DEXCOM G6 RECEIVER, DEXCOM G6 SENSOR, DEXCOM G6 TRANSMITTER, DEXCOM G7 RECEIVER, DEXCOM G7 SENSOR, FREESTYLE LIBRE 14 DAY READER, FREESTYLE LIBRE 14 DAY SENSOR, FREESTYLE LIBRE 2 PLUS SENSOR, FREESTYLE LIBRE 2 READER, FREESTYLE LIBRE 2 SENSOR, FREESTYLE LIBRE 3 PLUS SENSOR, FREESTYLE LIBRE 3 READER, FREESTYLE LIBRE 3 SENSOR, FREESTYLE LIBRE READER, FREESTYLE LIBRE SENSOR SYSTEM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/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 is treated with insulin at least once per day OR has a history of problematic hypoglycemia with documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose less than 54mg/dL (3.0mmol/L) that persist despite multiple (2 or more) attempts to adjust medication(s) and/or modify the diabetes treatment plan, or, a history of one level 3 hypoglycemic event (glucose less than 54mg/dL (3.0mmol/L) characterized by

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

PART B PREREQUISITE

N/A

COPIKTRA_NVT_2024

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

COTELLIC_NVT_2024

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For unresectable or metastatic melanoma: Documentation is provided of appropriate BRAF V600E or V600K mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CYSTARAN_NVT_2024

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CYSTEAMINE_(UCARE)_2024

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
Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
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
Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.

PART B PREREQUISITE
N/A

DALFAMPRIDINE_(UCARE)_2024

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years and older (initial and continuation therapy)

PRESCRIBER RESTRICTION
MS - prescribed by or in consultation with a neurologist or MS specialist (initial and continuation).

COVERAGE DURATION
Initial - 4months, Continuation - 1 year.

OTHER CRITERIA
Initial-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has impaired ambulation as evaluated by an objective measure (e.g., timed 25 foot walk and multiple sclerosis walking scale-12). Continuation-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.

PART B PREREQUISITE
N/A

DARAPRIM_NVT_2024

MEDICATION(S)
PYRIMETHAMINE 25 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DAURISMO_NVT_2024

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

DEFERASIROX_(UCARE)_2024

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
Serum ferritin level

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Transfusion-related chronic iron overload, initial therapy – approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy – approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy – approve is the patient is benefiting from therapy as confirmed by the prescribing physician.

PART B PREREQUISITE
N/A

DIACOMIT_NVT_2024

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DRONABINOL_NVT_2024

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Approval will be based off BvD coverage determination.

PART B PREREQUISITE
N/A

DUPIXENT_NVT_2024

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initial requests: For atopic dermatitis: Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For asthma: History, within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Both of the following were ineffective or not tolerated: a) an oral corticosteroid AND b) a nasal corticosteroid. For eosinophilic esophagitis: Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For asthma: 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 initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter) OR 2) Oral corticosteroid-dependent asthma requiring daily doses of 5 mg or greater prednisone (or equivalent). For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis: Both of the following apply: a) diagnosis has persisted for at least 6 weeks, AND b) at least 20 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

EMGALITY_NVT_2024

MEDICATION(S)
EMGALITY, EMGALITY (300 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ENBREL_NVT_2024

MEDICATION(S)
ENBREL 25 MG/0.5ML SOLN PRSYR, ENBREL 25 MG/0.5ML SOLUTION, ENBREL 50 MG/ML SOLN PRSYR, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. 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, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

ENDARI_NVT_2024

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a hematologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

EPIDIOLEX_NVT_2024

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ERIVEDGE_NVT_2024

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ERLEADA_NVT_2024

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ESBRIET_NVT_2024

MEDICATION(S)
PIRFENIDONE 267 MG CAP, PIRFENIDONE 267 MG TAB, PIRFENIDONE 801 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

EXKIVITY_NVT_2024

MEDICATION(S)
EXKIVITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of EGFR exon 20 insertion mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FANAPT_NVT_2024

MEDICATION(S)
FANAPT, FANAPT TITRATION PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FASENRA_NVT_2024

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For asthma (initial requests): History within the last year of at least 1 asthma exacerbation requiring one of following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For eosinophilic granulomatosis with polyangiitis (EGPA)(initial requests): Both of the following: A) Trial of oral corticosteroid therapy was ineffective or not tolerated and B) One of the following was ineffective or not tolerated: a) cyclophosphamide OR b) methotrexate. 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: 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

FERRIPROX_NVT_2024

MEDICATION(S)
DEFERIPRONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FINTEPLA_NVT_2024

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FIRDAPSE_NVT_2024

MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

FIRMAGON_NVT_2024

MEDICATION(S)
FIRMAGON, FIRMAGON (240 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FOTIVDA_NTV_2024

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FRUZAQLA_NVT_2024

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FYCOMPA_NVT_2024

MEDICATION(S)
FYCOMPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For partial-onset seizures: Both of the following were ineffective or not tolerated: a) topiramate AND b) 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 or epilepsy specialist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GAVRETO_NVT_2024

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of RET gene fusion.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GILOTRIF_NVT_2024

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation. For squamous non-small cell lung cancer: Documentation of EGFR mutation 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

GLP-1_AGONISTS_(UCARE)_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/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 - Approve if member has been using the requested medication within the past 180 days.

PART B PREREQUISITE
N/A

GROWTH HORMONES NP_NVT_2024

MEDICATION(S)
SKYTROFA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GROWTH HORMONES_NVT_2024

MEDICATION(S)
OMNITROPE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HADLIMA_NVT_2024

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate 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, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in

consult with, a rheumatology specialist OR ophthalmologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HAE AGENTS_NVT_2024

MEDICATION(S)
CINRYZE, HAEGARDA, ICATIBANT ACETATE, RUCONEST, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HARVONI_NVT_2024

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Genotype is provided 2) Current HCV-RNA titer is provided 3) Member does or does not have cirrhosis. 4) No prior treatment with a direct-acting antiviral for hepatitis C. 5) Member is intolerant to, or unable to use both of the following: a) Mavyret AND b) Epclusa.

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

HETLIOZ_NVT_2024

MEDICATION(S)
HETLIOZ, TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For non-24-hour sleep-wake disorder: Member is totally blind. For Smith-Magenis syndrome: Diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a neurologist or sleep specialist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HRM_BENZODIAZEPINES_(UCARE)_2024

MEDICATION(S)

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

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Procedure-related sedation - 1 month. All other conditions - 12 months.

OTHER CRITERIA

Insomnia - Approve lorazepam, temazepam, or oxazepam if the patient has had a trial with two of the following: ramelteon, trazodone, doxepin 3mg or 6 mg. Prior to approval, the physician must have assessed risk versus benefit for the patient and must confirm that they would still like to initiate/continue therapy. All medically accepted indications other than insomnia - Approve.

PART B PREREQUISITE

N/A

MEDICATION(S)
HUMIRA (2 PEN) 40 MG/0.4ML AUT-IJ KIT, HUMIRA (2 PEN) 40 MG/0.8ML AUT-IJ KIT, HUMIRA (2 SYRINGE), HUMIRA 10 MG/0.1ML PREF SY KT (ABBVIE), HUMIRA 20 MG/0.2ML PREF SY KT (ABBVIE), HUMIRA 40 MG/0.4ML PREF SY KT (ABBVIE), HUMIRA PEN 80 MG/0.8ML PEN KIT (ABBVIE), HUMIRA PEN-CD/UC/HS STARTER 80 MG/0.8ML PEN KIT (ABBVIE), HUMIRA-CD/UC/HS STARTER, HUMIRA-PED<40KG CROHNS STARTER, HUMIRA-PED>/=40KG CROHNS START, HUMIRA-PED>/=40KG UC STARTER, HUMIRA-PS/UV/ADOL HS STARTER, HUMIRA-PSORIASIS/UVEIT STARTER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate 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, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist.

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

IBRANCE_NVT_2024

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Kisqali.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ICLUSIG_NVT_2024

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IDHIFA_NVT_2024

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of IDH2 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IMATINIB_(UCARE)_2024

MEDICATION(S)
IMATINIB MESYLATE

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
ASM, DFSP, HES, MDS/MPD/Myeloid/Lymphoid Neoplasms-18 years and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For ALL/CML, must have Ph-positive for approval of imatinib. Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)-patient has tried Turalio or according to the prescriber, the patient cannot take Turalio. Myelodysplastic/myeloproliferative disease-approve if the condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.Graft versus host disease, chronic-approve if the patient has tried at least one conventional systemic treatment (e.g., imbruvica). Metastatic melanoma-approve if the patient has c-Kit-positive advanced/recurrent or metastatic melanoma. Myeloid/lymphoid neoplasms with

eosinophilia-approve if the tumor has an ABL1 rearrangement or an FIP1L1-PDGFRA or PDGFRB rearrangement.

PART B PREREQUISITE

N/A

IMBRUVICA_NVT_2024

MEDICATION(S)
IMBRUVICA 140 MG CAP, 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

INCRELEX_NVT_2024

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INGREZZA_NVT_2024

MEDICATION(S)
INGREZZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INLYTA_NVT_2024

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INQOVI_NVT_2024

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INREBIC_NVT_2024

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of Jakafi was ineffective or not tolerated.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IRESSA_NVT_2024

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ITRACONAZOLE_NVT_2024

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION, ITRACONAZOLE 100 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IVIG_NVT_2024

MEDICATION(S)
GAMMAKED 1 GM/10ML SOLUTION, GAMUNEX-C 1 GM/10ML SOLUTION, HYQVIA, PRIVIGEN 20 GM/200ML 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
Approval will be based off BvD coverage determination.

PART B PREREQUISITE
N/A

IWILFIN_NVT_2024

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

JAKAFI_NVT_2024

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

JAYPIRCA_NVT_2024

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

KALYDECO_NVT_2024

MEDICATION(S)
KALYDECO 13.4 MG PACKET, KALYDECO 25 MG PACKET, KALYDECO 5.8 MG PACKET, KALYDECO 50 MG PACKET, KALYDECO 75 MG PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KERENDIA_NVT_2024

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KEVZARA_NVT_2024

MEDICATION(S)
KEVZARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For rheumatoid arthritis, polymyalgia rheumatica, and polyarticular juvenile idiopathic arthritis: Prescribed by, or in consultation with, a rheumatology specialist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KISQALI_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KORLYM_NVT_2024

MEDICATION(S)
KORLYM, MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KOSELUGO_NVT_2024

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documentation is provided that indicates inoperable and symptomatic disease

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KRAZATI_NVT_2024

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of KRAS G12C mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KUVAN_NVT_2024

MEDICATION(S)
SAPROPTERIN DIHYDROCHLORIDE 100 MG PACKET, SAPROPTERIN DIHYDROCHLORIDE 500 MG PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LAZCLUZE_NVT_2024

MEDICATION(S)
LAZCLUZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LENVIMA_NVT_2024

MEDICATION(S)
LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LETAIRIS_NVT_2024

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIBERVANT_NVT_2024

MEDICATION(S)
LIBERVANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIDOCAINE_PATCH_(UCARE)_2024

MEDICATION(S)
LIDOCAINE PATCHES RX ONLY

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

LONG_ACTING_OPIOIDS_(UCARE)_2024

MEDICATION(S)
BELBUCA, BUPRENORPHINE 10 MCG/HR PATCH WK, BUPRENORPHINE 15 MCG/HR PATCH WK, BUPRENORPHINE 20 MCG/HR PATCH WK, BUPRENORPHINE 5 MCG/HR PATCH WK, BUPRENORPHINE 7.5 MCG/HR PATCH WK, METHADONE HCL 10 MG TAB, METHADONE HCL 10 MG/5ML SOLUTION, METHADONE HCL 5 MG TAB, METHADONE HCL 5 MG/5ML SOLUTION, MORPHINE SULFATE ER 100 MG TAB ER, MORPHINE SULFATE ER 15 MG TAB ER, MORPHINE SULFATE ER 200 MG TAB ER, MORPHINE SULFATE ER 30 MG TAB ER, MORPHINE SULFATE ER 60 MG TAB ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Acute (ie, 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, approve if all of the following criteria are met: 1) patient 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 (eg, 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. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

PART B PREREQUISITE

N/A

LONSURF_NVT_2024

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LORBRENA_NVT_2024

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ALK-positive disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LUMAKRAS_NVT_2024

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of KRAS G12C mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LYNPARZA_NVT_2024

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LYTGOBI_NVT_2024

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
Documentation is provided of FGFR2 fusion or other rearrangement

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MAVYRET_NVT_2024

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Current HCV-RNA titer is provided 2) Member does not have decompensated cirrhosis 3) One of the following: a) no prior treatment with a direct-acting antiviral for hepatitis C, OR b) prior treatment with sofosbuvir-based regimen and all of the following: i) Member does not have genotype 3 AND ii) No prior treatment with an NS3/4A protease inhibitor.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEGESTROL SUSP_NVT_2024

MEDICATION(S)
MEGESTROL ACETATE 40 MG/ML SUSPENSION, MEGESTROL ACETATE 400 MG/10ML SUSPENSION, MEGESTROL ACETATE 625 MG/5ML SUSPENSION, MEGESTROL ACETATE 800 MG/20ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEGESTROL TABS_NVT_2024

MEDICATION(S)
MEGESTROL ACETATE 20 MG TAB, MEGESTROL ACETATE 40 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEKINIST_NVT_2024

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate BRAF V600E or V600K mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEKTOVI_NVT_2024

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate BRAF V600E or V600K mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MIGRANAL_NVT_2024

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of two different triptans was ineffective or not tolerated.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MODAFINIL_ARMODAFINIL_(UCARE)_2024

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

AGE RESTRICTION
Fatigue due to MS and Idiopathic hypersomnia - 18 years of age and older. All others - 17 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be for 12 months.

OTHER CRITERIA
Excessive daytime sleepiness associated with Shift Work Sleep Disorder (SWSD) - Approve if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults - Approve if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome - Approve. 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. Idiopathic hypersomnia - Approve.

PART B PREREQUISITE

N/A

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, REBIF, REBIF REBIDOSE, REBIF REBIDOSE TITRATION PACK, REBIF TITRATION PACK, TERIFLUNOMIDE, VUMERITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis. For Avonex, Kesimpta, Plegridy, Rebif, Vumerity: must first try one of teriflunomide, dimethyl fumarate, fingolimod, or glatiramer acetate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NERLYNX_NVT_2024

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NEXAVAR_NVT_2024

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NEXVIAZYME_UCARE_2024

MEDICATION(S)
NEXVIAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
1 year and older

PRESCRIBER RESTRICTION
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
1 year

OTHER CRITERIA
Acid alpha-glucosidase deficiency (Pompe Disease)-approve if the patient has late-onset acid alpha-glucosidase deficiency (late-onset Pompe Disease) and the diagnosis is established by laboratory test demonstrating deficient acid alpha-glucosidase activity in the blood, fibroblasts or muscle tissue or patient has a molecular genetic test demonstrating acid alpha-glucosidase gene mutation.

PART B PREREQUISITE
N/A

NILUTAMIDE_(UCARE)_2024

MEDICATION(S)
NILUTAMIDE

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
Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.

PART B PREREQUISITE
N/A

NINLARO_NVT_2024

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NORTHERA_NVT_2024

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

NOURIANZ_NVT_2024

MEDICATION(S)
NOURIANZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One agent from both of the following classes was ineffective or not tolerated: a) COMT inhibitor AND b) MAO-B 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

NOXAFIL_NVT_2024

MEDICATION(S)
POSACONAZOLE 100 MG TAB DR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUBEQA_NVT_2024

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For metastatic hormone-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated.
For non-metastatic castration-resistant prostate cancer: Trial of other agents not required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUEDEXTA_NVT_2024

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUPLAZID_NVT_2024

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NURTEC_(UCARE)_2024

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Migraine, acute treatment – Pt has tried at least one triptan therapy or has a contraindication to triptans according to the prescriber. Preventive treatment of episodic migraine - Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants OR the member has already tried an oral or injectable calcitonin gene-related peptide (CGRP) inhibitor indicated for the prevention of migraine or Botox (onabotulinumtoxinA injection) for the prevention of migraines. For continuation requests: Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OCTREOTIDE_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ODOMZO_NVT_2024

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OFEV_NVT_2024

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

OGSIVEO_NVT_2024

MEDICATION(S)
OGSIVEO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OJEMDA_NVT_2024

MEDICATION(S)
OJEMDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OJJAARA_NVT_2024

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ONUREG_NVT_2024

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

OPSUMIT_NVT_2024

MEDICATION(S)
OPSUMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORENCIA_NVT_2024

MEDICATION(S)
ORENCIA 125 MG/ML SOLN PRSYR, ORENCIA 50 MG/0.4ML SOLN PRSYR, ORENCIA 87.5 MG/0.7ML SOLN PRSYR, ORENCIA CLICKJECT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

ORFADIN_NVT_2024

MEDICATION(S)
NITISINONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORGOVYX_NVT_2024

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORKAMBI_NVT_2024

MEDICATION(S)
ORKAMBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORSERDU_NVT_2024

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ESR1 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OTEZLA_NVT_2024

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For oral ulcers associated with Behcet's disease (initial requests): Trial of topical triamcinolone 0.1% oral paste was ineffective or not tolerated. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. 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.

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

OXERVATE_NVT_2024

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Eye to be treated has never been treated with Oxervate in the past.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by an ophthalmologist.

COVERAGE DURATION
Approved for 3 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PANRETIN_NVT_2024

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PART D VS PART B

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, APREPITANT, ARFORMOTEROL TARTRATE, AZATHIOPRINE 50 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), 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, DEXTROSE 10 % SOLUTION, DEXTROSE-SODIUM CHLORIDE 10-0.2 % SOLUTION, DEXTROSE-SODIUM CHLORIDE 10-0.45 % SOLUTION, DIPHTHERIA-TETANUS TOXOIDS DT, ENGERIX-B, ENVARSUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), HYDROMORPHONE HCL PF 10 MG/ML SOLUTION, HYDROMORPHONE HCL PF 50 MG/5ML SOLUTION, HYDROMORPHONE HCL PF 500 MG/50ML SOLUTION, IMOVAX RABIES, INSULIN ASPART, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, METHYLPREDNISOLONE 16 MG TAB, METHYLPREDNISOLONE 32 MG TAB, METHYLPREDNISOLONE 4 MG TAB, METHYLPREDNISOLONE 8 MG TAB, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NOVOLOG, NOVOLOG RELION, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLUTION, PLENAMINE, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 20 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, VARUBI (180 MG DOSE)

DETAILS

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

PEGASYS_(UCARE)_2024

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PEMAZYRE_NVT_2024

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate FGFR fusion or rearrangement.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PENICILLAMINE_(UCARE)_2024

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
Wilson’s Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PHENYLBUTYRATE_(UCARE)_2024

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 Ravicti and Buphenyl

REQUIRED MEDICAL INFORMATION
Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)

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
Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval

OTHER CRITERIA
Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.

PART B PREREQUISITE
N/A

PIQRAY_NVT_2024

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
Documentation is provided of PIK3CA-mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

POMALYST_NVT_2024

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

PRALUENT_NVT_2024

MEDICATION(S)
PRALUENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of Repatha 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

PROMACTA_NVT_2024

MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

QINLOCK_NVT_2024

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

QUININE_NVT_2024

MEDICATION(S)
QUININE SULFATE 324 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 1 month.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RADICAVA_NVT_2024

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

RELISTOR_NVT_2024

MEDICATION(S)
RELISTOR 12 MG/0.6ML SOLUTION, RELISTOR 8 MG/0.4ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care: Trial of lactulose was ineffective or not tolerated.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 4 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RELTONE_NVT_2024

MEDICATION(S)
RELTONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of generic ursodiol 300 mg capsule 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

REPATHA_NVT_2024

MEDICATION(S)
REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RETACRIT_NVT_2024

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RETEVMO_NVT_2024

MEDICATION(S)
RETEVMO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of RET mutation or RET gene fusion.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REVATIO_NVT_2024

MEDICATION(S)
SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REVLIMID_NVT_2024

MEDICATION(S)
LENALIDOMIDE, REVLIMID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZLIDHIA_NVT_2024

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of IDH1 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZUROCK_NVT_2024

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RILUZOLE_(UCARE)_2024

MEDICATION(S)
RILUZOLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RINVOQ_NVT_2024

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) Humira or Hadlima OR b) Enbrel. For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima 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 Humira or Hadlima was ineffective or not tolerated. For ankylosing spondylitis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For non-radiographic axial spondyloarthritis (initial requests): Trial of Cimzia was ineffective or not tolerated. For Crohn’s disease (initial requests): Trial of Humira or Hadlima was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): One of the following was ineffective or not tolerated: a) Humira or Hadlima OR b) Enbrel. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, or juvenile idiopathic arthritis: 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) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

PART B PREREQUISITE
N/A

ROZLYTREK_NVT_2024

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided showing one of the following: a) ROS1 rearrangement OR b) NTRK gene fusion mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RUBRACA_NVT_2024

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RYDAPT_NVT_2024

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SABRIL_NVT_2024

MEDICATION(S)
VIGABATRIN, VIGADRONE, VIGPODER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SCEMBLIX_NVT_2024

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SECUADO_NVT_2024

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SENSIPAR_(UCARE)_2024

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
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hypercalcemia d/t parathyroid CA-prescr/consult w/onco or endo.Hypercalcemia w/primary hyperparathyroidism-prescr/consult w/nephro or endo. Hyperparathyroidism in post-renal transplant-prescr/consult w/transplant physician/nephro/endo.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Hypercalcemia due to parathyroid carcinoma-approve. Hypercalcemia in patients with primary hyperparathyroidism-approve if the patient has failed or is unable to undergo a parathyroidectomy due to a contraindication. Secondary Hyperparathyroidism in patients with chronic kidney disease on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundles payment benefit). 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.

PART B PREREQUISITE

N/A

SIGNIFOR_NVT_2024

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SIMLANDI_(UCARE)_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

SIMPONI_NVT_2024

MEDICATION(S)
SIMPONI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Rinvoq OR d) Xeljanz. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq, OR i) Xeljanz. For ulcerative colitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira or Hadlima, b) Stelara, c) Rinvoq, d) Xeljanz, e) Skyrizi, or f) Tremfya. For continuation requests (all diagnoses): Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For 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

SIRTURO_NVT_2024

MEDICATION(S)
SIRTURO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SIVEXTRO_NVT_2024

MEDICATION(S)
SIVEXTRO 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SKYRIZI_NVT_2024

MEDICATION(S)
SKYRIZI 150 MG/ML SOLN PRSYR, SKYRIZI 180 MG/1.2ML SOLN CART, SKYRIZI 360 MG/2.4ML SOLN CART, SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

SOLARAZE_NVT_2024

MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SOMAVERT_NVT_2024

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SPRYCEL_NVT_2024

MEDICATION(S)
DASATINIB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

STELARA_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

STIVARGA_NVT_2024

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SUCRAID_NVT_2024

MEDICATION(S)
SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SUNOSI_NVT_2024

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis.

PART B PREREQUISITE
N/A

SUTENT_NVT_2024

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

SYNRIBO_NVT_2024

MEDICATION(S)
SYNRIBO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SYPRINE_NVT_2024

MEDICATION(S)
TRIENTINE HCL 250 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TABRECTA_NVT_2024

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of MET exon 14 skipping mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAFINLAR_NVT_2024

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate BRAF V600E or V600K mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAGRISSO_NVT_2024

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TALTZ_NVT_2024

MEDICATION(S)
TALTZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 10mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) 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 and 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

TALZENNA_NVT_2024

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TARCEVA_NVT_2024

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation. For pancreatic cancer: Documentation of EGFR mutation 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

TARGRETIN_NVT_2024

MEDICATION(S)
BEXAROTENE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TASIGNA_NVT_2024

MEDICATION(S)
TASIGNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAZVERIK_NVT_2024

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TEPMETKO_NVT_2024

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of MET exon 14 skipping mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TERIPARATIDE_(UCARE)_2024

MEDICATION(S)
TERIPARATIDE, TERIPARATIDE (RECOMBINANT)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other medications for osteoporosis

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
High risk for fracture-2 yrs, Not high risk-approve a max of 2 yrs of therapy (total)/lifetime.

OTHER CRITERIA
Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase 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 hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position

post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture. Patients who have already taken teriparatide for 2 years - approve if the patient is at high risk for fracture.

PART B PREREQUISITE

N/A

TESTOSTERONE_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

TIBSOVO_NVT_2024

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of IDH1 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TIOPRONIN_NVT_2024

MEDICATION(S)
TIOPRONIN 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

TOBI_NVT_2024

MEDICATION(S)
TOBRAMYCIN 300 MG/4ML NEBU SOLN, 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

TOLCAPONE_(UCARE)_2024

MEDICATION(S)
TOLCAPONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis, use of carbidopa/levodopa, and use of entacapone and associated clinical outcome

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Parkinson's disease-approve if the patient is currently receiving carbidopa/levodopa therapy and the patient has tried entacapone and according to the prescriber, experienced significant intolerance or inadequate efficacy.

PART B PREREQUISITE
N/A

TOPICAL_RETINOID_(UCARE)_2024

MEDICATION(S)
AVITA 0.025 % CREAM, TAZAROTENE 0.05 % GEL, TAZAROTENE 0.1 % CREAM, TAZAROTENE 0.1 % GEL, TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.05 % GEL, TRETINOIN 0.1 % CREAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Coverage is not provided for cosmetic use.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TRACLEER_NVT_2024

MEDICATION(S)
BOSENTAN

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

TRANSDERMAL_FENTANYL_(UCARE)_2024

MEDICATION(S)
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
'For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient 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 (eg, 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, sickle cell

disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

PART B PREREQUISITE

N/A

TRANSMUCOSAL_FENTANYL_(UCARE)_2024

MEDICATION(S)
FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG LOZ HANDLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.

PART B PREREQUISITE

N/A

TRIKAFTA_NVT_2024

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TRUQAP_NVT_2024

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of PIK3CA, AKT1, or PTEN alteration.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TUKYSA_NVT_2024

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TURALIO_NVT_2024

MEDICATION(S)
TURALIO 125 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TYENNE_NVT_2024

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

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Systemic sclerosis-associated interstitial lung disease

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

TYKERB_NVT_2024

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

UCERIS_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of mesalamine was ineffective or not tolerated.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

UPTRAVI_NVT_2024

MEDICATION(S)
UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VALCHLOR_NVT_2024

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VANFLYTA_NVT_2024

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of an FLT3 internal tandem duplication (ITD) mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VENCLEXTA_NVT_2024

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

VERKAZIA_(UCARE)_2024

MEDICATION(S)
VERKAZIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
4 years and older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an optometrist or ophthalmologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Vernal keratoconjunctivitis-approve if the patient has moderate to severe vernal keratoconjunctivitis and has tried one other ophthalmic medication for the maintenance treatment of vernal keratoconjunctivitis. Note: Examples of other ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic antihistamines and ophthalmic mast-cell stabilizers (e.g.,lodoxamide tromethamine 0.1% ophthalmic solution). A previous trial of one ophthalmic cyclosporine product (e.g., Cequa [cyclosporine 0.09% ophthalmic solution], Restasis [cyclosporine 0.05% ophthalmic emulsion]) other than the requested drug also counts as a trial of one agent for vernal keratoconjunctivitis.

PART B PREREQUISITE
N/A

VERZENIO_NVT_2024

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VIGAFYDE_NVT_2024

MEDICATION(S)
VIGAFYDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VIJOICE_NVT_2024

MEDICATION(S)
VIJOICE 125 MG TAB THPK, VIJOICE 200 & 50 MG TAB THPK, VIJOICE 50 MG TAB THPK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of mutation in the PIK3CA gene. For continuation requests: Member has benefited with use of this medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VITRAKVI_NVT_2024

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of NTRK gene fusion mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VIZIMPRO_NVT_2024

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate EGFR mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VONJO_NVT_2024

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VORANIGO_NVT_2024

MEDICATION(S)
VORANIGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate IDH mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VORICONAZOLE_NVT_2024

MEDICATION(S)
VORICONAZOLE 200 MG TAB, VORICONAZOLE 50 MG TAB, VORICONAZOLE 200 MG RECON SOLN, VORICONAZOLE 40 MG/ML RECON SUSP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VOSEVI_NVT_2024

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Coverage duration of 12 weeks.

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

PART B PREREQUISITE
N/A

VOTRIENT_NVT_2024

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

VYNDAMAX_NVT_2024

MEDICATION(S)
VYNDAMAX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

WEGOVY_MEDD_(UCARE)_2024

MEDICATION(S)
WEGOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Weight loss

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Reduction of major adverse cardiovascular events - Approve if the patient has established cardiovascular disease defined as a prior myocardial infarction, prior stroke, or peripheral arterial disease AND patient has a BMI of 27 or greater AND patient does not have type 1 or type 2 diabetes.

PART B PREREQUISITE
N/A

WEIGHT LOSS DRUGS_UCARE_2024

MEDICATION(S)
SAXENDA, WEGOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use of other weight loss medications other than phentermine

REQUIRED MEDICAL INFORMATION
Diagnosis, weight, baseline BMI and baseline weight, previous medications tried

AGE RESTRICTION
12 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial - 6 months. Continuation - 1 year

OTHER CRITERIA
Weight loss - Approve if pt has a baseline BMI of 30 kg/m2 or greater or has a BMI of 27 kg/m2 or greater with at least one weight-related comorbidity AND pt has tried phentermine (unless contraindicated) in combination with lifestyle modifications for at least 3 months and has been unsuccessful in meeting their weight loss goals or unable to tolerate phentermine and will continue these lifestyle modifications while taking the requested weight loss medication. Phentermine trial or contraindication is required. Continuation - Approve if pt continues to utilize lifestyle modifications for weight loss and has maintained at least a 5% reduction in body weight from baseline.

PART B PREREQUISITE
N/A

WELIREG_NVT_2024

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

XALKORI_NVT_2024

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ALK-positive or ROS1-positive disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XCOPRI_NVT_2024

MEDICATION(S)
XCOPRI, XCOPRI (250 MG DAILY DOSE) 100 & 150 MG TAB THPK, XCOPRI (350 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XDEMVY_(UCARE)_2024

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 6 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XELJANZ_NVT_2024

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

XERMELO_NVT_2024

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

XGEVA_NVT_2024

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XIFAXAN 550MG_NVT_2024

MEDICATION(S)
XIFAXAN 550 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

XOLAIR_NVT_2024

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

XOSPATA_NVT_2024

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of FLT3 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XPOVIO_NVT_2024

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XTANDI_NVT_2024

MEDICATION(S)
XTANDI

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XYREM_NVT_2024

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For excessive daytime sleepiness with narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

PART B PREREQUISITE
N/A

XYWAV_NVT_2024

MEDICATION(S)
XYWAV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
For excessive daytime sleepiness with narcolepsy and idopathic hypersomnia: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration.

PART B PREREQUISITE
N/A

ZAVESCA_NVT_2024

MEDICATION(S)
MIGLUSTAT, YARGESA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZEJULA_NVT_2024

MEDICATION(S)
ZEJULA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZELBORAF_NVT_2024

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of appropriate BRAF V600E or V600 mutation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZOLINZA_NVT_2024

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZTALMY_NVT_2024

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of a CDKL5 gene mutation

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZURZUVAE_NVT_2024

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 1 month.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZYDELIG_NVT_2024

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZYKADIA_NVT_2024

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of ALK-positive disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A