people powered health plans

2025 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: 12/01/2025

H5937_5248_072022_C_ 19
H2456_5248_072022 accepted

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)_2025

MEDICATION(S)
ABIRATERONE ACETATE, ABIRTEGA

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

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

PART B PREREQUISITE

N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ACTEMRA_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

ACTIMMUNE_NVT_2025

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ADALIMUMAB-AATY_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

ADBRY_(UCARE)_2025

MEDICATION(S)
ADBRY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

ADCIRCA_NVT_2025

MEDICATION(S)
ALYQ, TADALAFIL (PAH)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AFINITOR_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AIMOVIG_(UCARE)_2025

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AJOVY_NVT_2025

MEDICATION(S)
AJOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AKEEGA_NVT_2025

MEDICATION(S)
AKEEGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALECENSA_NVT_2025

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALUNBRIG_NVT_2025

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALYFTREK_NVT_2025

MEDICATION(S)
ALYFTREK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ARCALYST_NVT_2025

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ARIKAYCE_NVT_2025

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ATTRUBY_NVT_2025

MEDICATION(S)
ATTRUBY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

AUGTYRO_NVT_2025

MEDICATION(S)
AUGTYRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AUSTEDO_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AVMAPKI FAKZYNJA_NVT_2025

MEDICATION(S)
AVMAPKI FAKZYNJA CO-PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AYVAKIT_NVT_2025

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BALVERSA_NVT_2025

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BANZEL_NVT_2025

MEDICATION(S)
RUFINAMIDE 200 MG TAB, RUFINAMIDE 400 MG TAB, RUFINAMIDE 40 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BENLYSTA_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

BESREMI_NVT_2025

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BOMYNTRA_NVT_2025

MEDICATION(S)
BOMYNTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BOSULIF_NVT_2025

MEDICATION(S)
BOSULIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRAFTOVI_NVT_2025

MEDICATION(S)
BRAFTOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRUKINSA_NVT_2025

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CABOMETYX_NVT_2025

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CALQUENCE_NVT_2025

MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAPLYTA_NVT_2025

MEDICATION(S)
CAPLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAPRELSA_NVT_2025

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CARBAGLU_NVT_2025

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAYSTON_NVT_2025

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CIALIS_NVT_2025

MEDICATION(S)
TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

COBENFY_NVT_2025

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

COMETRIQ_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CONTINUOUS GLUCOSE MONITORS_UCARE_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 3 years.

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

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

PART B PREREQUISITE

N/A

COPIKTRA_NVT_2025

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

COSENTYX_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

COTELLIC_NVT_2025

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CYSTARAN_NVT_2025

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CYSTEAMINE_(UCARE)_2025

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use of Cystagon and Procysbi

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

DALFAMPRIDINE_(UCARE)_2025

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
For multiple sclerosis (MS): 18 years and older

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

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

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

PART B PREREQUISITE
N/A

DARAPRIM_(UCARE)_2025

MEDICATION(S)
PYRIMETHAMINE 25 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DAURISMO_NVT_2025

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DEMSER_NVT_2025

MEDICATION(S)
METYROSINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DIACOMIT_NVT_2025

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DRONABINOL_NVT_2025

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Approval will be based off BvD coverage determination.

PART B PREREQUISITE
N/A

DUPIXENT_NVT_2025

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

EMGALITY_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ENBREL_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

ENDARI_NVT_2025

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

EPIDIOLEX_NVT_2025

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ERIVEDGE_NVT_2025

MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ERLEADA_NVT_2025

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ESBRIET_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

EXXUA_NVT_2025

MEDICATION(S)
EXXUA, EXXUA TITRATION PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FANAPT_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FASENRA_NVT_2025

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

FINTEPLA_NVT_2025

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FIRDAPSE_NVT_2025

MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by a neurologist.

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

FIRMAGON_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FOTIVDA_NTV_2025

MEDICATION(S)
FOTIVDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FRUZAQLA_NVT_2025

MEDICATION(S)
FRUZAQLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FYCOMPA_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GAVRETO_NVT_2025

MEDICATION(S)
GAVRETO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GILOTRIF_NVT_2025

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GLP-1_AGONISTS_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

GOMEKLI_NVT_2025

MEDICATION(S)
GOMEKLI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GROWTH HORMONES_NVT_2025

MEDICATION(S)
OMNITROPE, SKYTROFA 11 MG CARTRIDGE, SKYTROFA 13.3 MG CARTRIDGE, SKYTROFA 3.6 MG CARTRIDGE, SKYTROFA 3 MG CARTRIDGE, SKYTROFA 4.3 MG CARTRIDGE, SKYTROFA 5.2 MG CARTRIDGE, SKYTROFA 6.3 MG CARTRIDGE, SKYTROFA 7.6 MG CARTRIDGE, SKYTROFA 9.1 MG CARTRIDGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HADLIMA_NVT_2025

MEDICATION(S)
HADLIMA, HADLIMA PUSHTOUCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

HAE AGENTS_NVT_2025

MEDICATION(S)
HAEGARDA, ICATIBANT ACETATE, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

HARVONI_(UCARE)_2025

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HERNEXEOS_NVT_2025

MEDICATION(S)
HERNEXEOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HRM_BENZODIAZEPINES_(UCARE)_2025

MEDICATION(S)

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

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

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

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

IBRANCE_NVT_2025

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IBTROZI_NVT_2025

MEDICATION(S)
IBTROZI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ICLUSIG_NVT_2025

MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IDHIFA_NVT_2025

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IMATINIB_(UCARE)_2025

MEDICATION(S)
IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB

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

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

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

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

PART B PREREQUISITE

N/A

IMBRUVICA_NVT_2025

MEDICATION(S)
IMBRUVICA 140 MG CAP, IMBRUVICA 420 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IMKELDI_NVT_2025

MEDICATION(S)
IMKELDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Member is unable to swallow solid dosage forms of imatinib.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INCRELEX_NVT_2025

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INGREZZA_NVT_2025

MEDICATION(S)
INGREZZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INLURIYO_NVT_2025

MEDICATION(S)
INLURIYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INLYTA_NVT_2025

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INQOVI_NVT_2025

MEDICATION(S)
INQOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

INREBIC_NVT_2025

MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IRESSA_NVT_2025

MEDICATION(S)
GEFITINIB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ITOVEBI_NVT_2025

MEDICATION(S)
ITOVEBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ITRACONAZOLE_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for a duration of 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

IVIG_NVT_2025

MEDICATION(S)
GAMMAKED, GAMUNEX-C, PRIVIGEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Approval will be based off BvD coverage determination.

PART B PREREQUISITE
N/A

IWILFIN_NVT_2025

MEDICATION(S)
IWILFIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

JADENU_NVT_2025

MEDICATION(S)
DEFERASIROX 180 MG TAB, DEFERASIROX 360 MG TAB, DEFERASIROX 90 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

JAKAFI_NVT_2025

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

JAYPIRCA_NVT_2025

MEDICATION(S)
JAYPIRCA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

JOURNAVX_(UCARE)_2025

MEDICATION(S)
JOURNAVX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 month

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KALYDECO_NVT_2025

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KERENDIA_NVT_2025

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KEVZARA_(UCARE)_2025

MEDICATION(S)
KEVZARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

KISQALI_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KORLYM_NVT_2025

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KOSELUGO_NVT_2025

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KRAZATI_NVT_2025

MEDICATION(S)
KRAZATI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KUVAN_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LAZCLUZE_NVT_2025

MEDICATION(S)
LAZCLUZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LENVIMA_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LETAIRIS_NVT_2025

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIBERVANT_NVT_2025

MEDICATION(S)
LIBERVANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIDOCAINE_PATCH_(UCARE)_2025

MEDICATION(S)
LIDOCAINE PATCHES 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

LIVTENCITY_NVT_2025

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for 3 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LONG_ACTING_OPIOIDS_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

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

PART B PREREQUISITE

N/A

LONSURF_NVT_2025

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LORBRENA_NVT_2025

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LUMAKRAS_NVT_2025

MEDICATION(S)
LUMAKRAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LYNPARZA_NVT_2025

MEDICATION(S)
LYNPARZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LYTGOBI_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MAVYRET_NVT_2025

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEGESTROL SUSP_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEGESTROL TABS_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEKINIST_NVT_2025

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEKTOVI_NVT_2025

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MIGRANAL_NVT_2025

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MODAFINIL_ARMODAFINIL_(UCARE)_2025

MEDICATION(S)
ARMODAFINIL, MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

dystrophy: Approve modafinil.

PART B PREREQUISITE

N/A

MODEYSO_NVT_2025

MEDICATION(S)
MODEYSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MS_AGENTS_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NEMLUVIO_NVT_2025

MEDICATION(S)
NEMLUVIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

NERLYNX_NVT_2025

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NEXAVAR_NVT_2025

MEDICATION(S)
SORAFENIB TOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NEXVIAZYME_UCARE_2025

MEDICATION(S)
NEXVIAZYME

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

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

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

NILUTAMIDE_(UCARE)_2025

MEDICATION(S)
NILUTAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

NINLARO_NVT_2025

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NORTHERA_NVT_2025

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NOXAFIL_NVT_2025

MEDICATION(S)
POSACONAZOLE 100 MG TAB DR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUBEQA_NVT_2025

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUEDEXTA_NVT_2025

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUPLAZID_NVT_2025

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NURTEC_(UCARE)_2025

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OCTREOTIDE_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ODOMZO_NVT_2025

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OFEV_NVT_2025

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

OGSIVEO_NVT_2025

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_2025

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_2025

MEDICATION(S)
OJJAARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ONUREG_NVT_2025

MEDICATION(S)
ONUREG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OPIPZA_NVT_2025

MEDICATION(S)
OPIPZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OPSUMIT_NVT_2025

MEDICATION(S)
OPSUMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORENCIA_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

ORGOVYX_NVT_2025

MEDICATION(S)
ORGOVYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORKAMBI_NVT_2025

MEDICATION(S)
ORKAMBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORSERDU_NVT_2025

MEDICATION(S)
ORSERDU

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OTEZLA_NVT_2025

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

PANRETIN_NVT_2025

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 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, APREPITANT, ARFORMOTEROL TARTRATE, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 50 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOSPORINE, CYCLOSPORINE MODIFIED 100 MG CAP, CYCLOSPORINE MODIFIED 25 MG CAP, CYCLOSPORINE MODIFIED 50 MG CAP, CYCLOSPORINE MODIFIED, DIPHTHERIA-TETANUS TOXOIDS DT, ENGERIX-B, ENVARSUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HUMULIN R U-500 (CONCENTRATED), IMOVAX RABIES, INSULIN ASPART, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, METHYLPREDNISOLONE 16 MG TAB, METHYLPREDNISOLONE 32 MG TAB, METHYLPREDNISOLONE 4 MG TAB, METHYLPREDNISOLONE 8 MG TAB, 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/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLUTION, PLENAMINE, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 25 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 6.7 (5 BASE) MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 15 MG/5ML SOLUTION, PREDNISOLONE SODIUM PHOSPHATE 6.7 (5 BASE) MG/5ML SOLUTION, PREDNISONE 10 MG TAB, PREDNISONE 1 MG TAB, PREDNISONE 20 MG TAB, PREDNISONE 2.5 MG TAB, PREDNISONE 50 MG TAB, PREDNISONE 5 MG TAB, PREDNISONE 10 MG TAB, PREDNISONE 1

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

DETAILS

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

PEGASYS_(UCARE)_2025

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PEMAZYRE_NVT_2025

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PENICILLAMINE_(UCARE)_2025

MEDICATION(S)
PENICILLAMINE 250 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PHENYLBUTYRATE_(UCARE)_2025

MEDICATION(S)
SODIUM PHENYLBUTYRATE 500 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

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

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

PART B PREREQUISITE
N/A

PIQRAY_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

POMALYST_NVT_2025

MEDICATION(S)
POMALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREVYMIS_NVT_2025

MEDICATION(S)
PREVYMIS 120 MG PACKET, PREVYMIS 240 MG TAB, PREVYMIS 480 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PROMACTA_NVT_2025

MEDICATION(S)
ELTROMBOPAG OLAMINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

QINLOCK_NVT_2025

MEDICATION(S)
QINLOCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

QUININE_NVT_2025

MEDICATION(S)
QUININE SULFATE 324 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 1 month.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RADICAVA_NVT_2025

MEDICATION(S)
RADICAVA ORS, RADICAVA ORS STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RALDESY_NVT_2025

MEDICATION(S)
RALDESY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Member is unable to swallow solid dosage forms of trazodone.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RETACRIT_NVT_2025

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RETEVMO_NVT_2025

MEDICATION(S)
RETEVMO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REVATIO_NVT_2025

MEDICATION(S)
SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REVLIMID_NVT_2025

MEDICATION(S)
LENALIDOMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REVUFORJ_NVT_2025

MEDICATION(S)
REVUFORJ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZDIFFRA_NVT_2025

MEDICATION(S)
REZDIFFRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZLIDHIA_NVT_2025

MEDICATION(S)
REZLIDHIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZUROCK_NVT_2025

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RILUZOLE_(UCARE)_2025

MEDICATION(S)
RILUZOLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RINVOQ_(UCARE)_2025

MEDICATION(S)
RINVOQ, RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

gastroenterologist.

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

ROMVIMZA_NVT_2025

MEDICATION(S)
ROMVIMZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ROZLYTREK_NVT_2025

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RUBRACA_NVT_2025

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RYDAPT_NVT_2025

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SABRIL_NVT_2025

MEDICATION(S)
VIGABATRIN, VIGADRONE, VIGPODER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SAXENDA

MEDICATION(S)
LIRAGLUTIDE -WEIGHT MANAGEMENT, SAXENDA

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

SCEMBLIX_NVT_2025

MEDICATION(S)
SCEMBLIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SECUADO_NVT_2025

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SENSIPAR_(UCARE)_2025

MEDICATION(S)
CINACALCET HCL

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

OFF LABEL USES
Hyperparathyroidism in post-renal transplant patients

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE

N/A

SIGNIFOR_NVT_2025

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SIMLANDI_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION

Approved for duration of 1 year.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

SKYRIZI_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SOLARAZE_NVT_2025

MEDICATION(S)
DICLOFENAC SODIUM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SOMAVERT_NVT_2025

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SPRYCEL_NVT_2025

MEDICATION(S)
DASATINIB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

STELARA_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

STEQEYMA_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

STIVARGA_NVT_2025

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SUCRAID_NVT_2025

MEDICATION(S)
SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SUNOSI_NVT_2025

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
A nocturnal polysomnogram was used to confirm diagnosis.

PART B PREREQUISITE
N/A

SUTENT_NVT_2025

MEDICATION(S)
SUNITINIB MALATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SYPRINE_NVT_2025

MEDICATION(S)
TRIENTINE HCL 250 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TABRECTA_NVT_2025

MEDICATION(S)
TABRECTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAFINLAR_NVT_2025

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAGRISSO_NVT_2025

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TALZENNA_NVT_2025

MEDICATION(S)
TALZENNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TARCEVA_NVT_2025

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TARGRETIN_NVT_2025

MEDICATION(S)
BEXAROTENE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TASIGNA_NVT_2025

MEDICATION(S)
NILOTINIB HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAZORAC_NVT_2025

MEDICATION(S)
TAZAROTENE 0.1 % CREAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TAZVERIK_NVT_2025

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TEPMETKO_NVT_2025

MEDICATION(S)
TEPMETKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TERIPARATIDE_(UCARE)_2025

MEDICATION(S)
TERIPARATIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other medications for osteoporosis

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

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

PART B PREREQUISITE

N/A

TESTOSTERONE_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

TIBSOVO_NVT_2025

MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TOBI_NVT_2025

MEDICATION(S)
TOBRAMYCIN 300 MG/5ML NEBU SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Approval will be based off BvD coverage determination.

PART B PREREQUISITE
N/A

TRACLEER_NVT_2025

MEDICATION(S)
BOSENTAN 125 MG TAB, BOSENTAN 62.5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TRANSMUCOSAL_FENTANYL_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

TRIKAFTA_NVT_2025

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TRUQAP_NVT_2025

MEDICATION(S)
TRUQAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TUKYSA_NVT_2025

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TURALIO_NVT_2025

MEDICATION(S)
TURALIO 125 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TYENNE_(UCARE)_2025

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

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

OFF LABEL USES
Systemic sclerosis-associated interstitial lung disease

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

TYKERB_NVT_2025

MEDICATION(S)
LAPATINIB DITOSYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TYRVAYA_(UCARE)_2025

MEDICATION(S)
TYRVAYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

UCERIS_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

UPTRAVI_(UCARE)_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VALCHLOR_NVT_2025

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VANFLYTA_NVT_2025

MEDICATION(S)
VANFLYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VENCLEXTA_NVT_2025

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VERZENIO_NVT_2025

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VIGAFYDE_NVT_2025

MEDICATION(S)
VIGAFYDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VITRAKVI_NVT_2025

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VIZIMPRO_NVT_2025

MEDICATION(S)
VIZIMPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VONJO_NVT_2025

MEDICATION(S)
VONJO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VOQUEZNA_(UCARE)_2025

MEDICATION(S)
VOQUEZNA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approval duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VORANIGO_NVT_2025

MEDICATION(S)
VORANIGO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VORICONAZOLE_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VOSEVI_NVT_2025

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Coverage duration of 12 weeks.

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

PART B PREREQUISITE
N/A

VOTRIENT_NVT_2025

MEDICATION(S)
PAZOPANIB HCL 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VOWST_NVT_2025

MEDICATION(S)
VOWST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 1 month.

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

PART B PREREQUISITE
N/A

VYNDAMAX_NVT_2025

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)_2025

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
For MASH: Prescribed by, or in consultation with, a hepatologist or gastroenterologist

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
Reduction of major adverse cardiovascular events - Approve if the member 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. For MASH (initial requests): Members diagnosis has been confirmed by liver biopsy performed within the previous 3 years OR confirmed by a noninvasive test (NITs) (for example, transient elastography, vibration-controlled transient elastography [for example, Fibroscan] or magnetic resonance elastography) within the past 6 months AND the results of the liver biopsy or NIT demonstrate stage F2 or F3 fibrosis AND the member is receiving standard of care pharmacologic treatment to manage comorbid diseases (for example, cardiovascular disease, dyslipidemia, diabetes, hypertension) AND the member does not have evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma (HCC) AND the member’s alcohol consumption is less than or equal to 20 g/day in females or less than

or equal to 30 g/day for males. For MASH (continuation requests): Documentation is provided showing the member has experienced improvement or stabilization of fibrosis as verified by noninvasive tests AND has not progressed to stage F4 fibrosis.

PART B PREREQUISITE

N/A

WEIGHT LOSS DRUGS_UCARE_2025

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_2025

MEDICATION(S)
WELIREG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

WINREVAIR_NVT_2025

MEDICATION(S)
WINREVAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by right heart catheterization.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

WYOST_NVT_2025

MEDICATION(S)
WYOST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XALKORI_NVT_2025

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XCOPRI_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XDEMVY_(UCARE)_2025

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 6 weeks.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XELJANZ_(UCARE)_2025

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

XERMELO_NVT_2025

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XIFAXAN 550MG_NVT_2025

MEDICATION(S)
XIFAXAN 550 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

XOLAIR_NVT_2025

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

XOSPATA_NVT_2025

MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XPOVIO_NVT_2025

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XTANDI_NVT_2025

MEDICATION(S)
XTANDI

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

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

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XYREM_NVT_2025

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

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

PART B PREREQUISITE
N/A

ZEJULA_NVT_2025

MEDICATION(S)
ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZELBORAF_NVT_2025

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZOLINZA_NVT_2025

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZTALMY_NVT_2025

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided of a CDKL5 gene mutation

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZURZUVAE_NVT_2025

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for 1 month.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZYDELIG_NVT_2025

MEDICATION(S)
ZYDELIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZYKADIA_NVT_2025

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for duration of 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A