ACTHAR GEL (S)

Products Affected

- Acthar
- Acthar Gel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Infantile Spasms (IS) (West Syndrome): Diagnosis of IS (West Syndrome). Multiple Sclerosis (MS): Diagnosis of acute exacerbation of MS. One of the following: 1) Both of the following: a) Patient is new to therapy with corticotropin AND b) Trial and failure, contraindication, or intolerance (TF/C/I) to treatment with two high dose corticosteroid treatments (e.g., prednisone, IV methylprednisolone) OR 2) All of the following: a) Patient's MS exacerbations have been treated in the past with corticotropin AND b) Patient has benefitted from treatment with corticotropin for acute exacerbations of MS AND c) Medication is being used to treat a new exacerbation of MS. Other FDA-Approved Indications: Diagnosis of one of the following: 1) Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis, or acute gouty arthritis, OR 2) Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, or systemic dermatomyositis (polymyositis), OR 3) Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome, or severe psoriasis, OR 4) Allergic states: Serum sickness or atopic dermatitis, OR 5) Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as one of the following: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, OR 6) Respiratory diseases: Symptomatic sarcoidosis, OR 7) Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. TF/C/I to treatment with two corticosteroids (e.g., prednisone, methylprednisolone).

Age Restrictions	Infantile spasms: less than 2 years old
Prescriber Restrictions	Infantile Spasm, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.
Coverage Duration	Infantile Spasms: 4 weeks. MS: 3 weeks. All other FDA-approved uses: 3 months.
Other Criteria	IS: Dosing for IS (West Syndrome) is in accordance with the United States Food and Drug Administration (FDA) approved labeling: not to exceed 150U/m^2 daily. MS: Dosing for MS is in accordance with the United States FDA approved labeling: not to exceed 120 units once daily. Other FDA-Approved Indications: Dosing is in accordance with the United States FDA approved labeling: not to exceed 80 units per day.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ACTIMMUNE (S)

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADAKVEO (S)

Products Affected

- Adakveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Sickle Cell Disease. Documentation of 2 vaso-occlusive events that required medical facility visits and treatments in the past 12 months (e.g., sickle cell crisis, acute pain episodes, acute chest syndrome, hepatic sequestration, splenic sequestration, priapism). Trial and failure or inadequate response, contraindication, or intolerance to Hydroxyurea.
Age Restrictions	Initial: Patient is 16 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: 1) Hematologist/Oncologist or 2) Specialist w/ expertise in the diagnosis and management of sickle cell disease.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADALIMUMAB-AATY (S)

Products Affected

- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A

Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.
Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADALIMUMAB-ADBM (S)

Products Affected

- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A

Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADBRY (S)

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least two of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADCETRIS (S)

Products Affected

- Adcetris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADCIRCA (S)

Products Affected

- Adcirca
- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADEMPAS (S)

Products Affected

- Adempas
- Riociguat

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, CTEPH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADSTILADRIN (S)

Products Affected

- Adstiladrin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADZYNMA (S)

Products Affected

- Adzynma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP). Molecular genetic testing confirms mutations in the ADAMTS13 gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AEMCOLO (S)

Products Affected

- Aemcolo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Travelers' diarrhea (TD): Diagnosis of TD. Diarrhea is not accompanied by fever or bloody stool. One of the following: 1) Trial and failure to one of the following: Zithromax (azithromycin), Cipro (ciprofloxacin), Levaquin (levofloxacin), or ofloxacin OR 2) Resistance, contraindication, or intolerance to all of the following antibiotics: Zithromax (azithromycin), Cipro (ciprofloxacin), Levaquin (levofloxacin), or ofloxacin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AFINITOR (S)

Products Affected

- Afinitor
- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast Cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AFINITOR DISPERZ (S)

Products Affected

- Afinitor Disperz
- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older. TSC-associated partial-onset seizures: Patient is 2 years of age or older.
Prescriber Restrictions	TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AFREZZA (S)

Products Affected

- Afrezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: 1) Diagnosis of type 1 diabetes mellitus and used in combination with a long-acting insulin (eg, Lantus) OR 2) Diagnosis of type 2 diabetes mellitus. Patient has a documented FEV1. Will NOT be approved in patients with chronic lung disease [e.g., asthma, chronic obstructive pulmonary disease (COPD)]. Trial and failure or intolerance to Humalog and Novolog.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: Repeat pulmonary function test confirms that the patient has NOT experienced a decline of 20% or more in FEV1 from baseline. Patient demonstrates positive clinical response to therapy. Patient does not have chronic lung disease (e.g., asthma, COPD).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AGAMREE (S)

Products Affected

- Agamree

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Duchenne muscular dystrophy (DMD). Patient has received genetic testing for a mutation of the dystrophin gene. One of the following: A) Presence of a confirmed mutation of the dystrophin gene, or B) Muscle biopsy confirmed an absence of dystrophin protein. Trial and failure or intolerance to prednisone or prednisolone. Initial, Reauth: One of the following: A) For patients less than or equal to 50kg, dose will not exceed 6mg/kg of body weight once daily, or B) For patients greater than 50kg, dose will not exceed 300mg/day.
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a benefit from therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AIMOVIG (S)

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AJOVY (S)

Products Affected

- Ajovy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): One of the following: 1) Patient is under 18 years of age or 2) Both of the following: a) Patient is 18 years of age or older and b) Trial and failure, contraindication, or intolerance to Aimovig and Emgality. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AKEEGA (S)

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer. Disease is both of the following: a) metastatic and b) deleterious or suspected deleterious BRCA-mutated (BRCAm). Used in combination with prednisone. One of the following: a) Used in combination with a gonadotropin-releasing hormone (GnRH) analog, or b) Patient has had a bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALDURAZYME (S)

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis I: confirmed diagnosis of Hurler or Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I), OR confirmed diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I) who have moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALECENSA (S)

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALIQOPA (S)

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALPHA-1 PROTEINASE INHIBITOR, NON-PREFERRED (S)

Products Affected

- Aralast Np INJ 1000MG, 500MG
- Glassia
- Zemaira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. One of the following: Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry) OR the patient has a concomitant diagnosis of necrotizing panniculitis. Trial and failure, or intolerance to Prolastin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ALPHA-1 PROTEINASE INHIBITOR, PROLASTIN (S)

Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry), unless the patient has a concomitant diagnosis of necrotizing panniculitis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial, reauth): 12 months
Other Criteria	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALUNBRIG (S)

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALVAIZ (S)

Products Affected

- Alvaiz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune thrombocytopenia (ITP) (initial): Diagnosis of one of the following: a) persistent ITP, b) chronic ITP, or c) relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to one of the following: a) corticosteroids (e.g., prednisone, methylprednisolone), b) immunoglobulins [e.g., Gammagard, immune globulin (human)], or c) splenectomy. Severe aplastic anemia (SAA) (initial): Diagnosis of refractory SAA. Patient has one of the following: a) neutrophils less than 0.5 x 10^9/L, b) platelets greater than 20 x 10^9/L, or c) reticulocytes less than 60 x 10^9/L. Insufficient response to immunosuppressive therapy. Chronic hepatitis C (Hep C)-associated thrombocytopenia (initial): Diagnosis of chronic Hep C-associated thrombocytopenia. One of the following: 1) Planning to initiate and maintain interferon-based treatment, or 2) currently receiving interferon-based treatment.
Age Restrictions	N/A
Prescriber Restrictions	ITP, SAA (initial): Prescribed by or in consultation with a hematologist/oncologist. Chronic Hep C-associated thrombocytopenia (initial): Prescribed by or in consultation with one of the following: hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	ITP (init): 12 mo. SAA (init): 16 wk. Hep C (init): 3 mo. All uses (reauth): 12 mo.

Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count. Chronic Hep C-associated thrombocytopenia (reauth): Patient currently on antiviral interferon therapy for treatment of chronic Hep C.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ALYFTREK (S)

Products Affected

- Alyftrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cystic fibrosis (CF). Presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). CFTR mutation is responsive based on clinical and/or in vitro data OR CFTR mutation results in the production of CFTR protein.
Age Restrictions	Initial: Patient is 6 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALYMSYS (S)

Products Affected

- Alymsys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Trial and failure, or intolerance to Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AMONDYS 45 (S)

Products Affected

- Amondys 45

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following: a) diagnosis of Duchenne muscular dystrophy (DMD) and b) patient has a mutation of the dystrophin gene amenable to exon 45 skipping. Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly. Submission of medical records (e.g., chart notes, laboratory values) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient is tolerating therapy, dose will not exceed 30 mg/kg of body weight infused once weekly, and submission of medical records (e.g., chart notes, laboratory values) confirming the patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AMPYRA (S)

Products Affected

- Ampyra
- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (Initial): 6 months. (Reauth): 12 months.
Other Criteria	MS (Reauth): Physician confirmation that the patient's walking improved with therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AMVUTTRA (S)

Products Affected

- Amvuttra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis with polyneuropathy (hATTR-PN) (Initial): Diagnosis of hATTR-PN. Presence of a transthyretin (TTR) mutation (e.g., V30M) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: 1) Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, OR 2) Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, OR 3) Patient has a baseline neuropathy impairment score (NIS) greater than or equal to 5 and less than or equal to 130, OR 4) Patient has a baseline Karnofsky Performance Status score greater than or equal to 60%. Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy, walking ability, quality of life). Requested drug is not used in combination with a TTR silencer (e.g., Tegsedi) or a TTR stabilizer (e.g., Vyndaqel). Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (Initial): Diagnosis of ATTR-CM. One of the following: 1) Presence of a TTR mutation (e.g., V122I) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) Both of the following: a) Cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis and b) Absence of light-chain amyloidosis. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Onpattro).
Age Restrictions	N/A
Prescriber Restrictions	hATTR-PN (Initial): Prescribed by or in consultation with a neurologist. ATTR-CM (Initial, Reauth): Prescribed by or in consultation with a cardiologist.

Coverage Duration	All Uses (Initial, Reauth): 12 months
Other Criteria	hATTR-PN (Reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to have a polyneuropathy disability (PND) score less than or equal to IIIb, OR 2) Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, OR 3) Patient continues to have a neuropathy impairment score (NIS) greater than or equal to 5 and less than or equal to 130, OR 4) Patient continues to have a Karnofsky Performance Status score greater than or equal to 60%. Requested drug is not used in combination with a TTR silencer (e.g., Tegsedi) or a TTR stabilizer (e.g., Vyndaqel). ATTR-CM (Reauth): Patient continues to have NYHA Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Onpattro).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ANDEMBRY (S)

Products Affected

- Andembry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 12 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ANKTIVA (S)

Products Affected

- Anktiva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

APOKYN (S)

Products Affected

- Apokyn INJ 30MG/3ML
- Apomorphine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	PD (Initial): Not used with any 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of PD. Patient is experiencing acute intermittent hypomobility (defined as “off” episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Used in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, etc.).
Age Restrictions	N/A
Prescriber Restrictions	PD (Initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	PD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AQNEURSA (S)

Products Affected

- Aqneursa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Niemann-Pick disease type C (NPC). Diagnosis is confirmed by one of the following: a) genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2, or b) mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (greater than 2 times upper limit of normal). Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia). Patient weighs greater than or equal to 15 kg. Requested drug will not be used in combination with Miplyffa (arimoclomol).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C.
Coverage Duration	Initial: 12 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Miplyffa (arimoclomol).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AQVESME (S)

Products Affected

- Aqvesme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of anemia with alpha or beta-thalassemia. Hemoglobin is less than or equal to 10g/dL. Patient is not on concurrent treatment with any of the following: 1) Reblozyl (luspatercept-aamt), 2) Hematopoietic stimulating agents (e.g., Epogen [epoetin alfa], Aranesp [darbepoetin alfa]), or 3) Pyrukynd (mitapivat).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist or hepatologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARANESP (S)

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. CKD (init, reauth), Chemo (init), MDS (init): Adequate iron stores confirmed by both of the following: a) Patient's ferritin level is greater than 100 mcg/L and b) Patient's transferrin saturation (TSAT) is greater than 20%. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD (Init): 6 mo. CKD (reauth): 12 mo. Chemo(init, reauth): 3 mo. MDS: (init) 3 mo,(reauth) 12 mo.

Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARBLI (S)

Products Affected

- Arbli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: 1) Both of the following: a) Diagnosis of hypertension and b) Patient is 6 years of age or older, 2) Diagnosis of hypertension with left ventricular hypertrophy, or 3) Diagnosis of nephropathy in type 2 diabetes. One of the following: 1) Trial or intolerance to generic losartan tablets, 2) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), or 3) Dosage requirements cannot be met with a solid dosage form.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARCALYST (S)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cryopyrin-Associated Periodic Syndromes (CAPS) (Initial): Diagnosis of CAPS, including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. Patient weighs at least 10 kg. Patient is currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L). Recurrent Pericarditis (Initial): Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart. Trial and failure, contraindication, or intolerance (TF/C/I) to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	CAPS (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or specialist with expertise in the management of CAPS. Recurrent Pericarditis (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CAPS, Recurrent Pericarditis (initial, reauth): 12 months. DIRA: 12 months.
Other Criteria	CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count. Recurrent Pericarditis (Reauth): Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARFORMOTEROL (S)

Products Affected

- Arformoterol Tartrate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of COPD. Used for maintenance treatment of bronchoconstriction in patients with COPD, including chronic bronchitis and emphysema.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD: 12 months.
Other Criteria	Subject to Part B vs. Part D review.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARIKAYCE (S)

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycobacterium avium complex (MAC) lung disease: Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ARYNTA (S)

Products Affected

- Arynta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD): Diagnosis of ADD or ADHD. Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube). Binge Eating Disorder (BED) (initial): Diagnosis of moderate to severe BED as confirmed by both of the following: a) patient has had BED for 3 months or longer, AND b) patient meets at least 3 of the following criteria: 1) patient eats much more rapidly than normal, 2) patient eats until feeling uncomfortably full, 3) patient eats large amounts of food when not feeling physically hungry, 4) patient eats alone because of feeling embarrassed by how much he or she is eating, 5) patient feels disgusted with himself or herself, depressed, or very guilty after binge eating. Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ADD/ADHD: 12 months. BED (initial, reauth): 12 months.
Other Criteria	BED (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARZERRA (S)

Products Affected

- Arzerra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ATEBRIOZ (S)

Products Affected

- Atebrioz

PA Criteria	Criteria Details
Indications	N/A
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A
Prerequisite Therapy Required	

AUBAGIO (S)

Products Affected

- Aubagio
- Teriflunomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUGTYRO (S)

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced, or b) metastatic. Patient has ROS1 rearrangement positive tumor(s). Solid Tumors: Diagnosis of solid tumors. Disease has neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1). Disease is one of the following: a) Locally advanced, b) Metastatic, or c) Unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: a) Disease has progressed following previous treatment (e.g., radiation therapy, systemic therapy, tyrosine kinase inhibitor [TKI]), or b) Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months.
Other Criteria	All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AURYXIA (S)

Products Affected

- Auryxia
- Ferric Citrate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Exclude if used for iron deficiency anemia in chronic kidney disease (CKD) not on dialysis.
Required Medical Information	Hyperphosphatemia in chronic kidney disease: Diagnosis of hyperphosphatemia. Patient has chronic kidney disease (CKD). Patient is on dialysis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Subject to ESRD review.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUSTEDO (S)

Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated with Huntington's disease. Tardive dyskinesia (initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.
Age Restrictions	N/A
Prescriber Restrictions	Huntington's disease chorea (initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AVASTIN (S)

Products Affected

- Avastin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Trial and failure, or intolerance to Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVLAYAH (S)

Products Affected

- Avlayah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Hunter syndrome (Mucopolysaccharidosis type II [MPS II]). Requested medication is initiated prior to advanced neurologic impairment (e.g., progressive cognitive decline, status epilepticus). Patient's weight is greater than or equal to 5 kg. Requested medication is not used in combination with other enzyme replacement therapies for the treatment of Hunter syndrome (e.g., Elaprase).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a geneticist, metabolic disease specialist, or physician who specializes in the treatment of lysosomal storage disorders.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested medication is not used in combination with other enzyme replacement therapies for the treatment of Hunter syndrome (e.g., Elaprase).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AVMAPKI FAKZYNJA (S)

Products Affected

- Avmapki Fakzynja Co-pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC). Presence of a KRAS-mutation as detected by a Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVSOLA (S)

Products Affected

- Avsola

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (eg, prednisone), methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Prescriber Restrictions	Initial: RA, AS: Prescribed by or in consultation with a rheumatologist. PsA: Prescribed or in consultation with a rheumatologist or dermatologist. Crohn's Disease, Fistulizing Crohn's Disease, UC: Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All indications (initial): 6 months, (reauth): 12 months.
Other Criteria	Ankylosing spondylitis (AS) (initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (initial): Dx of sarcoidosis. TF/C/I to one of the following: immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine) OR corticosteroid (eg, prednisone). Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVTOZMA IV (S)

Products Affected

- Avtozma INJ 200MG/10ML, 400MG/20ML, 80MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), or b) attestation demonstrating a trial may be inappropriate, OR c) For continuation of prior therapy. Systemic Juvenile Idiopathic arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. Cytokine Release Syndrome (CRS): Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [e.g., Kymriah (tisagenlecleuce), Yescarta (axicabtagene ciloleucel)]. Coronavirus disease 2019 (COVID-19): Diagnosis of COVID-19. Patient is hospitalized. Currently receiving systemic corticosteroids. Patient requires one of the following: supplemental oxygen, non-invasive mechanical ventilation, invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA, GCA (initial): Prescribed by or in consultation with a rheumatologist. CRS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration	RA, SJIA, PJIA, GCA (Init): 6 mo, (reauth): 12 mo. CRS: 2 mo. COVID-19: 14 days.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GCA (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVTOZMA SC (S)

Products Affected

- Avtozma INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. Minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated dose. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.
Age Restrictions	N/A
Prescriber Restrictions	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.

Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AYVAKIT (S)

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. Disease is one of the following: unresectable or metastatic. Presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Advanced Systemic Mastocytosis (AdvSM): Diagnosis of AdvSM. Patient has one of the following: a) aggressive systemic mastocytosis (ASM), b) systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or c) mast cell leukemia (MCL). Platelet count is greater than or equal to 50 x 10^9/L. Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than or equal to 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AZMIRO (S)

Products Affected

- Azmiro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (Initial), GD: Trial and failure or intolerance to both of the following generics: testosterone enanthate and testosterone cypionate. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BAFIERTAM (S)

Products Affected

- Bafiertam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BALVERSA (S)

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). Disease is one of the following: Locally advanced or Metastatic. Presence of susceptible fibroblast growth factor receptor (FGFR) 3 genetic alterations as detected by an U.S. Food and Drug Administration (FDA)-approved test (therascreen FGFR RGQ RT-PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed on or after at least one line of prior systemic therapy (e.g., chemotherapy). One of the following: 1) Patient had been treated with prior PD-1 inhibitor (e.g., Opdivo [nivolumab], Keytruda [pembrolizumab]) or PD-L1 inhibitor therapy (e.g., Bavencio [avelumab]) or 2) Patient is not a candidate for PD-1 or PD-L1 inhibitor therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BAVENCIO (S)

Products Affected

- Bavencio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BAXFENDY (S)

Products Affected

- Baxfendy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of one of the following: uncontrolled hypertension or resistant hypertension. Patient has not achieved target blood pressure (e.g., systolic blood pressure [SBP] less than 130 mmHg) after treatment with at least two of the following antihypertensive medications from different classes, unless there is a contraindication or intolerance to these medications, for a minimum 4 weeks each: a) One of the following: Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril) or Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), b) Thiazide-type or thiazide-like diuretic (e.g., hydrochlorothiazide, chlorthalidone), c) Calcium channel blocker (e.g., amlodipine, nifedipine), OR d) Mineralocorticoid receptor antagonist (MRA) (e.g., eplerenone, spironolactone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauthorization: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BELEODAQ (S)

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENLYSTA (S)

Products Affected

- Benlysta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)]). Lupus Nephritis (init): Diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide).
Age Restrictions	SLE, Lupus Nephritis (init): Benlysta IV (vial), SC (prefilled syringe): Patient is 5 years of age or older.
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist. Lupus Nephritis (init): Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	SLE, Lupus Nephritis (init, reauth): 6 months
Other Criteria	SLE, Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BEOVU (S)

Products Affected

- Beovu SOSY

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: neovascular (wet) age-related macular degeneration or diabetic macular edema. Trial and failure, contraindication or intolerance to compounded bevacizumab prepared by a 503(B) Outsourcing Facility OR Lucentis (ranibizumab)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BERINERT (S)

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BESPONSA (S)

Products Affected

- Besponsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BESREMI (S)

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of polycythemia vera. One of the following: a) Hemoglobin greater than 16.5 g/dL for men or hemoglobin greater than 16.0 g/dL for women or b) Hematocrit greater than 49% for men or hematocrit greater than 48% for women. One of the following: a) Presence of JAK2 V617F or JAK2 exon 12 mutation or b) Patient has subnormal serum erythropoietin level. For high-risk polycythemia vera only (patient greater than or equal to 60 years old and/or prior thrombosis history), trial and inadequate response, contraindication or intolerance to hydroxyurea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BIMZELX (S)

Products Affected

- Bimzelx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque Psoriasis (PsO) (initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), or one formulary ustekinumab product. Psoriatic Arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Either a TF/C/I to two of the following: Cosentyx SC, Enbrel, one formulary adalimumab product, Orencia (abatacept), Otezla, Skyrizi, Sotyktu, Tremfya, one formulary ustekinumab product, Rinvoq/LQ (upadacitinib), or Xeljanz/XR (tofacitinib), OR b) for continuation of prior therapy. Non-radiographic axial spondyloarthritis (nr-axSpA) (initial): Dx of active nr-axSpA. Patient has objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.). One of the following: a) TF/C/I to Cosentyx SC and Rinvoq, OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS) (initial): Dx of active AS. One of the following: a) TF/C/I to two of the following: Enbrel, one formulary adalimumab product, Cosentyx SC, Rinvoq, Xeljanz/XR, OR for continuation of prior therapy. Hidradenitis suppurativa (HS) (initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). One of the following: a) TF/C/I to Cosentyx SC and one formulary adalimumab product, OR b) for continuation of prior therapy.
Age Restrictions	N/A

Prescriber Restrictions	PsO, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AS, nr-axSpA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	PsO, PsA, nr-axSpA, AS, HS (initial): 6 months. PsO, PsA, nr-axSpA, AS, HS (reauth): 12 months.
Other Criteria	PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BIZENGRI (S)

Products Affected

- Bizengri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BLINCYTO (S)

Products Affected

- Blincyto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL): Diagnosis of relapsed or refractory CD19-positive B-cell precursor acute lymphoblastic leukemia/acute lymphoblastic lymphoma. Minimal residual disease (MRD)-positive B-cell precursor ALL (MRD+ ALL): Diagnosis of CD19-positive B-cell precursor ALL. Patient is in their first or second complete remission. Documentation of MRD greater than or equal to 0.1%.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ALL: 12 months. MRD+ ALL: 6 months.
Other Criteria	Subject to Part B vs. Part D review. All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BLUJEPA (S)

Products Affected

- Blujepa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Uncomplicated Urinary Tract Infection (uUTI): Diagnosis of uUTI. Patient weighs at least 40kg. Trial and inadequate response, contraindication, or resistance to one alternative oral antibacterial treatment option (e.g., nitrofurantoin, trimethoprim-sulfamethoxazole, ciprofloxacin). Infection is caused by one of the following: a) Escherichia coli, b) Klebsiella pneumoniae, c) Citrobacter freundii complex, d) Staphylococcus saprophyticus, or e) Enterococcus faecalis. Uncomplicated Urogenital Gonorrhea (uUG): Diagnosis of uUG. Patient weighs at least 45kg. Trial and inadequate response, contraindication or resistance to one alternative antibacterial treatment option (e.g., IM ceftriaxone, oral azithromycin).
Age Restrictions	uUTI, uUG: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	uUTI: 5 days. uUG: 3 days.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BORTEZOMIB (S)

Products Affected

- Bortezomib
- Boruzu
- Velcade

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BOSULIF (S)

Products Affected

- Bosulif
- Bosutinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous/myeloid leukemia (CML): Diagnosis of Philadelphia chromosome-positive (Ph+) CML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BOTOX (S)

Products Affected

- Botox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuromuscular Disorders (init): Diagnosis of one of the following: Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), spasticity, VII cranial nerve disorders (hemifacial spasms), cervical dystonia. Hyperhidrosis(HH): (Init) Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Migraine:(Init) Dx of chronic migraines. Patient has greater than or equal to 8 migraine days per month. History of failure (after at least a two month trial), contraindication or intolerance to two of the following preventive treatments for migraine from different mechanisms of action: a) Elavil [amitriptyline] or Effexor [venlafaxine], b) Depakote/Depakote ER [divalproex sodium] or Topamax [topiramate], c) atenolol, propranolol, nadolol, timolol, or metoprolol, d) candesartan, e) Lisinopril. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Achalasia:(Init) High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of either nocturnal pain and bleeding or postdefecation pain. Chronic Back Pain (CBP):(Init) Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI):(init) Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis, spinal dysraphisms such as spina bifida) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB): (init) Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.
Age Restrictions	N/A

Prescriber Restrictions	Migraine (initial): Prescribed by a neurologist, pain specialist, or headache specialist. CBP (initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.
Coverage Duration	Achalasia: 6mo (init) 12mo (reauth). CBP: 1 tx(series of injxs). Other: 3mo (init) 12mo (reauth).
Other Criteria	UI, OAB, CBP, Neuromuscular Disorders:(Reauth) Patient demonstrates positive clinical response to therapy. At least 3 months have or will have elapsed since the last treatment. CBP:(Reauth) Treatment has not exceeded two treatment sessions total per year. HH:(Reauth) At least a 2-point improvement in HDSS. At least 3 months have or will have elapsed since the last series of injections. Migraine:(Reauth) Patient has experienced a positive response to therapy. Use of acute migraine medications [eg, nonsteroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen), triptans (eg, eletriptan, rizatriptan, sumatriptan)] has decreased since the start of therapy. At least 3 months have or will have elapsed since the last series of injections. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Achalasia:(Reauth) Documentation of improvement or reduction in symptoms of achalasia. At least 6 months have or will have elapsed since last series of injections. AF: (Reauth) Incomplete healing of fissure or recurrence of fissure. At least 3 months have or will have elapsed since the last series of injections.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRAFTOVI (S)

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib). Colorectal Cancer: One of the following diagnoses: Colon Cancer or Rectal Cancer. One of the following: 1) Unresectable or advanced disease or 2) Metastatic disease. Cancer is BRAF V600E mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following a) Used in combination with Erbitux (cetuximab) AND b) One of the following: i) Patient has received prior therapy OR ii) Used in combination with fluorouracil-based chemotherapy (e.g., mFOLFOX6, FOLFIRI). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BREKIYA (S)

Products Affected

- Brekiya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Migraine (Initial): Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: a) Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan), or b) Contraindication to all triptans. Trial or intolerance to generic dihydroergotamine mesylate injection. Cluster Headache (Initial): Diagnosis of cluster headache. Trial and failure, contraindication, or intolerance to sumatriptan injection. Trial or intolerance to generic dihydroergotamine mesylate injection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Migraine, Cluster Headache (Initial, Reauth): 12 months.
Other Criteria	Migraine (Reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Cluster Headache (Reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRINSUPRI (S)

Products Affected

- Brinsupri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of non-cystic fibrosis bronchiectasis (NCFB). Diagnosis has been confirmed by computed tomographic (CT) scan. Diagnostic testing confirms patient does not have cystic fibrosis. Patient has a clinical history consistent with NCFB (e.g., chronic cough or sputum production or recurrent respiratory tract infections). One of the following: 1) If patient is 12 to 17 years of age, patient has had at least one documented pulmonary exacerbation requiring treatment with systemic antibiotics in the previous 12 months, or 2) If patient is 18 years of age or older, patient has had at least two documented pulmonary exacerbations requiring treatment with systemic antibiotics in the previous 12 months. One of the following: 1) For patients with co-existing COPD, patient is receiving one of the following therapies at maximally tolerated doses: a) Triple therapy (i.e., an inhaled corticosteroid (ICS) [e.g., budenoside], a long-acting muscarinic antagonist (LAMA) [e.g., tiotropium, umeclidinium], and a long-acting beta agonist (LABA) [e.g., salmeterol, arformoterol, formoterol]), or b) If ICS are contraindicated, a LAMA and a LABA, or 2) For patients with co-existing asthma, patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) ICS (e.g., fluticasone propionate), and ii) Additional asthma controller medication (e.g., leukotriene receptor antagonist (LTRA) [e.g., montelukast], LABA [e.g., salmeterol], LAMA [e.g., tiotropium]), or b) One combination ICS/LABA product (e.g., Advair, Breo Ellipta), or 3) Patient does not have co-existing COPD or asthma.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by a pulmonologist.
Coverage Duration	Initial, Reauth: 12 months.

Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIUMVI (S)

Products Affected

- Briumvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesion). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS (e.g., Avonex [interferon beta-1a], Betaseron [interferon beta-1b], Gilenya [fingolimod]) OR 2) For continuation of prior therapy. MS (initial, reauth): Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (initial, reauth): 12 months.
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIVIACT (S)

Products Affected

- Brivaracetam SOLN
- Brivaracetam TABS
- Briviact

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Partial-onset seizures: Diagnosis of partial-onset seizures.
Age Restrictions	Patient is 1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRONCHITOL (S)

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cystic fibrosis (CF). Patient has passed the Bronchitol Tolerance Test (BTT).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BROVANA (S)

Products Affected

- Brovana

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of COPD. Used for maintenance treatment of bronchoconstriction in patients with COPD, including chronic bronchitis and emphysema. Trial and failure, contraindication, or intolerance to Perforomist (formoterol fumarate).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD: 12 months.
Other Criteria	Subject to Part B vs. Part D review.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRUKINSA (S)

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Patient has received at least one prior therapy for MCL [e.g., Calquence (acalabrutinib)]. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed or refractory. Patient has received at least one prior anti-CD20-based regimen for MZL (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of ONE of the following: CLL or SLL. Contraindication or intolerance to Calquence (acalabrutinib). Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Patient has received at least two prior lines of systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BYETTA BYDUREON (S)

Products Affected

- Exenatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BYLVAY (S)

Products Affected

- Bylvay
- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Progressive familial intrahepatic cholestasis (PFIC) (initial): Diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3, confirmed by one of the following: 1) Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis) or 2) Genetic testing. Alagille syndrome (ALGS) (initial): Both of the following: 1) Diagnosis of ALGS, and 2) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene.
Age Restrictions	N/A
Prescriber Restrictions	PFIC, ALGS (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	PFIC, ALGS (initial): 12 months. PFIC, ALGS (reauth): 12 months.
Other Criteria	PFIC (reauth): Patient demonstrates positive clinical response to therapy. ALGS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BYOOVIZ (S)

Products Affected

- Byooviz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: a) Neovascular (wet) age-related macular degeneration, b) Macular edema following retinal vein occlusion, OR c) Myopic choroidal neovascularization. Trial and failure, contraindication, or intolerance to compounded bevacizumab (e.g., Avastin).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CABLIVI (S)

Products Affected

- Cablivi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acquired thrombotic thrombocytopenic purpura (aTTP): Diagnosis of aTTP. First dose was/will be administered by a healthcare provider as a bolus intravenous injection. Used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids). One of the following: 1) Used in combination with plasma exchange or 2) both of the following: patient has completed plasma exchange and less than 59 days have or will have elapsed beyond the last plasma exchange.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CABOMETYX (S)

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate). Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease or patient is refractory to radioactive iodine treatment or ineligible. Neuroendocrine Tumors: Diagnosis of one of the following: 1) Pancreatic neuroendocrine tumors (pNET) or 2) Extra-pancreatic neuroendocrine tumors (epNET). Disease is one of the following: 1) Unresectable, 2) Locally advanced, or 3) Metastatic. Tumors are well-differentiated. Patient has been previously treated (e.g., octreotide, lanreotide, chemotherapy).
Age Restrictions	DTC: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CALQUENCE (S)

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL). One of the following: A) All of the following: 1) Patient has received no prior therapy for MCL (e.g., bortezomib, rituximab), 2) Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and 3) Used in combination with bendamustine and rituximab, OR B) Patient has received at least one prior therapy for MCL. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAMZYOS (S)

Products Affected

- Camzyos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of obstructive hypertrophic cardiomyopathy (HCM). Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain). Patient has a left ventricular ejection fraction of greater than or equal to 55%. Patient has valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation. Trial and failure, contraindication, or intolerance to one of the following at a maximally tolerated dose: a) non-vasodilating beta blocker (e.g., bisoprolol, propranolol) or b) calcium channel blocker (e.g., verapamil, diltiazem).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	Reauthorization: Patient demonstrates positive clinical response to therapy (e.g., improved symptom relief). Patient has a left ventricular ejection fraction of greater than or equal to 50%.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPLYTA (S)

Products Affected

- Caplyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: asenapine, aripiprazole, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, ziprasidone. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate. Trial and failure, contraindication, or intolerance to quetiapine (IR or ER) or olanzapine. Major depressive disorder (MDD): Diagnosis of MDD. Used as adjunctive therapy with an antidepressant (e.g., escitalopram, sertraline, venlafaxine/desvenlafaxine, etc.). Trial and failure, contraindication, or intolerance to both of the following oral generic formulary atypical antipsychotic agents: aripiprazole and quetiapine IR/ER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPRELSA (S)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of one of the following: a) metastatic medullary thyroid cancer (MTC) or b) unresectable locally advanced MTC. Patient has symptomatic disease or progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CARDAMYST (S)

Products Affected

- Cardamyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of paroxysmal supraventricular tachycardia (PSVT). Drug will be used for conversion of acute symptomatic episodes of PSVT to sinus rhythm. Patient does not have any contraindication to etripamil (e.g., Heart failure, Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, electrophysiologist, or emergency medicine physician.
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CARISOPRODOL (S)

Products Affected

- Carisoprodol TABS
- Soma
- Vanadom

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication. If the patient is 65 years of age or older, the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CAYSTON (S)

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs.
Age Restrictions	CF (Initial): 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	CF (Initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CERDELGA (S)

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Gaucher disease type 1. Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test.
Age Restrictions	Gaucher disease: Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CEREZYME (S)

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Type 1 Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly). Type 3 Gaucher disease: Diagnosis of Type 3 Gaucher disease. Presence of a non-central nervous system (CNS) manifestation (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CHENODAL (S)

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of radiolucent gallstones. Patient has a well-opacifying gallbladder visualized by oral cholecystography. Trial and failure, contraindication or intolerance to ursodiol. Patient is not a candidate for surgery. Stones are not calcified (radiopaque) or radiolucent bile pigment stones.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist or provider who has specialized expertise in the management of gallstones
Coverage Duration	Initial, reauth: 12 months.
Other Criteria	Reauth: Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by oral cholecystograms or ultrasonograms.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CHOLBAM (S)

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of a peroxisomal disorder based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses: 4 months (initial), 12 months (reauth).
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement in liver function.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CHORIONIC GONADOTROPIN (S)

Products Affected

- Chorionic Gonadotropin INJ
- Novarel INJ 5000UNIT
- Pregnyl
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (MHH) (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and one of the following: a) low LH (below normal reference value provided by the physician's laboratory) or b) low FSH (below normal reference value provided by the physician's laboratory).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. MHH (initial, reauth): 12 months.
Other Criteria	Excluded if used to promote fertility. MHH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CIALIS (S)

Products Affected

- Cialis TABS 5MG
- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use of nitrates.
Required Medical Information	Diagnosis of benign prostatic hyperplasia (BPH). Trial and failure, contraindication, or intolerance to an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CIBINQO (S)

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. One of the following: 1) Trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to, Adbry [tralokinumab-ldrm], Dupixent [dupilumab], Ebglyss [lebrikizumab-lbkz], etc.), OR 2) Patient has a contraindication, intolerance, or treatment is inadvisable with two of the following FDA-approved atopic dermatitis therapies: Adbry (tralokinumab-ldrm), Dupixent (dupilumab), or Ebglyss (lebrikizumab-lbkz). Not used in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	(Initial): Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CICLOPIROX (S)

Products Affected

- Ciclodan SOLN
- Ciclopirox Nail Lacquer

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All of the following: 1) Patient does not have lunula (matrix) involvement, 2) one of the following: a) Diagnosis of onychomycosis of the toenails, OR b) Diagnosis of onychomycosis of the fingernails, 3) Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, 4) If toenail onychomycosis, patient has mild to moderate disease involving at least 1 target toenail, AND 5) One of the following: a) For onychomycosis of fingernails, Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine, or b) For onychomycosis of toenails, trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CIMERLI (S)

Products Affected

- Cimerli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: (Cimerli 0.5 mg) One of the following diagnoses: A) Neovascular (wet) age-related macular degeneration, B) Macular edema following retinal vein occlusion, OR C) Myopic choroidal neovascularization. (Cimerli 0.3 mg) One of the following diagnoses: A) Diabetic macular edema, OR B) Diabetic retinopathy. All Strengths/Indications: Trial and failure, contraindication, or intolerance to compounded bevacizumab (e.g., Avastin).
Age Restrictions	N/A
Prescriber Restrictions	All Strengths/Indications (Initial): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases
Coverage Duration	All Strengths/Indications (Initial, Reauth): 12 months
Other Criteria	All Strengths/Indications (Reauth): Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CIMZIA (S)

Products Affected

- Cimzia
- Cimzia (1 Syringe)
- Cimzia (2 Syringe)
- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA, initial): Diagnosis (dx) of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA, initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel, one formulary adalimumab product, Orencia, Rinvoq/LQ, or Xeljanz, OR b) for continuation of prior therapy. Psoriatic Arthritis (PsA, initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Either a TF/C/I to two of the following: Cosentyx SC (secukinumab), Enbrel, one formulary adalimumab product, Orencia, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq/LQ, or Xeljanz/XR, OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS, initial): Dx of active AS. TF/C/I to two of the following: Enbrel, one formulary adalimumab product, Cosentyx SC, Rinvoq, Xeljanz/XR, OR for continuation of prior therapy. Plaque Psoriasis (PsO) (initial): Dx of moderate to severe PsO. One of the following: at least 3% body surface area (BSA) involvement, OR palmoplantar (ie, palms, soles), facial, scalp, or genital involvement. TF/C/I to two of the following: one formulary adalimumab product, Enbrel, Otezla, Skyrizi, Sotyktu, Tremfya, one formulary ustekinumab product, Cosentyx, OR for continuation of prior therapy.
Age Restrictions	N/A

Prescriber Restrictions	CD (init): Prescribed by or in consultation with a gastroenterologist. RA, PJIA, AS, nr-axSpA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	CD, RA, PJIA, PsA, AS, PsO, nr-axSpA (init): 6 mo, (reauth): 12 mo.

Other Criteria	Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.). Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen) at maximally tolerated doses. Crohn's Disease (CD, initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to two of the following: one formulary adalimumab product, Rinvoq, Skyrizi, Tremfya, or one formulary ustekinumab product, OR for continuation of prior therapy. RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CINQAIR (S)

Products Affected

- Cinqair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR 2) Prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [e.g., Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/ formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	N/A
Prescriber Restrictions	Asthma (Initial): Prescribed by or in consultation with a pulmonologist or an allergist/immunologist.
Coverage Duration	Asthma (init): 6 months. Asthma (reauth): 12 months
Other Criteria	Asthma (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CINRYZE (S)

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COBENFY (S)

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: a) aripiprazole, b) asenapine, c) olanzapine, d) paliperidone, e) quetiapine (IR or ER), f) risperidone, or g) ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COLUMVI (S)

Products Affected

- Columvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COMETRIQ (S)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CONZIP (S)

Products Affected

- Conzip
- Tramadol Hcl Er CP24 100MG, 200MG, 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic pain: Diagnosis of severe and persistent pain that requires an extended treatment period with a daily opioid analgesic. Trial and failure, contraindication, or intolerance to both of the following: a tramadol containing product [eg, tramadol, tramadol/acetaminophen] and any one formulary long-acting opioid [eg, MS Contin (morphine controlled-release), Oxycontin (oxycodone ER)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COPIKTRA (S)

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease is relapsed or refractory. Trial and failure, contraindication, or intolerance to at least two prior therapies for CLL/SLL (e.g., Leukeran [chlorambucil], Gazyva [obinutuzumab], Arzerra [ofatumumab], Bendeka [bendamustine], Imbruvica [ibrutinib], Rituxan [rituximab], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CORTROPHIN (S)

Products Affected

- Cortrophin INJ 80UNIT/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Infantile Spasms (IS) (West Syndrome) [off-label]: Diagnosis of IS (West Syndrome). Multiple Sclerosis (MS): Diagnosis of acute exacerbation of MS. One of the following: 1) Both of the following: a) Patient is new to therapy with corticotropin AND b) Trial and failure, contraindication, or intolerance (TF/C/I) to treatment with two high dose corticosteroid treatments (e.g., prednisone, IV methylprednisolone) OR 2) All of the following: a) Patient's MS exacerbations have been treated in the past with corticotropin AND b) Patient has benefitted from treatment with corticotropin for acute exacerbations of MS AND c) Medication is being used to treat a new exacerbation of MS. Other FDA-Approved Indications: Diagnosis of one of the following: 1) Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis, or acute gouty arthritis, OR 2) Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus or systemic dermatomyositis (polymyositis), OR 3) Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome, or severe psoriasis, OR 4) Allergic states: Serum sickness or atopic dermatitis, OR 5) Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as one of the following: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, OR 6) Respiratory diseases: Symptomatic sarcoidosis, OR 7) Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. TF/C/I to treatment with two corticosteroids (e.g., prednisone, methylprednisolone).
Age Restrictions	IS: less than 2 years old

Prescriber Restrictions	IS, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.
Coverage Duration	IS: 4 weeks. MS: 3 weeks. Other FDA-Approved Indications: 3 months.
Other Criteria	IS: Dosing for IS (West Syndrome) is in accordance with the United States Food and Drug Administration (FDA) approved labeling: not to exceed 150U/m^2 daily. MS: Dosing for MS is in accordance with the United States FDA approved labeling: not to exceed 120 units once daily. Other FDA-Approved Indications: Dosing is in accordance with the United States FDA approved labeling: not to exceed 80 units per day.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COSELA (S)

Products Affected

- Cosela

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of extensive-stage small cell lung cancer (ES-SCLC). Patient is receiving one of the following anti-cancer chemotherapeutic regimens: platinum/etoposide-containing regimen or topotecan-containing regimen. Infusion is completed within 4 hours prior to the start of chemotherapy. The interval between doses on sequential days will not be greater than 28 hours.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COSENTYX (S)

Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS.
Age Restrictions	N/A

Prescriber Restrictions	Plaque psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COSENTYX IV (S)

Products Affected

- Cosentyx INJ 125MG/5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq/LQ (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: a) TF/C/I to two of the following: Cosentyx SC, Enbrel, one formulary adalimumab product, Rinvoq, Xeljanz/XR, OR b) for continuation of prior therapy. Non-radiographic axial spondyloarthritis (nr-axSpA) (Initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints). One of the following: a) TF/C/I to both of the following: Cosentyx SC and Rinvoq, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): 12 months.

Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the body surface area (BSA) involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COTELLIC (S)

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm. Used as monotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COXANTO (S)

Products Affected

- Coxanto
- Oxaprozin CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: a) Osteoarthritis, b) Rheumatoid arthritis, or c) Juvenile rheumatoid arthritis. Trial and failure, contraindication, or intolerance to two formulary nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRENESSITY (S)

Products Affected

- Crenessity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of classic 21-hydroxylase deficiency congenital adrenal hyperplasia. Patient is receiving chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone) for adrenal insufficiency.
Age Restrictions	Initial: Patient is 4 years of age or older.
Prescriber Restrictions	Initial: Prescribed by an endocrinologist. Reauth: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Patient continues to receive chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRESEMBA ORAL (S)

Products Affected

- Cresemba CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fungal infection: Diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRINONE (S)

Products Affected

- Crinone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRYSVITA (S)

Products Affected

- Crysvita

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	X-Linked Hypophosphatemia (XLH) (Initial): Diagnosis of XLH. One of the following: A) Patient is 6 months to 17 years of age, OR B) Both of the following: 1) Patient is 18 years of age or older, AND 2) Patient is a candidate for pharmacologic therapy by meeting one of the following: a) spontaneous insufficiency fractures, b) pending orthopedic procedures (e.g., joint replacement), c) biochemical evidence of osteomalacia (i.e., elevated serum alkaline phosphatase), d) disabling skeletal pain. Trial and failure, contraindication, or intolerance to conventional treatment with phosphate supplementation and vitamin D analog-based therapy (e.g., calcitriol, paricalcitol, doxercalciferol). Tumor-Induced Osteomalacia (TIO) (Initial): Diagnosis of FGF23-related hypophosphatemia in TIO. Tumor could not be curatively resected or localized. Trial and failure, contraindication, or intolerance to conventional treatment with phosphate supplementation and vitamin D analog-based therapy (e.g., calcitriol, paricalcitol, doxercalciferol).
Age Restrictions	TIO: Patient is at least 2 years of age.
Prescriber Restrictions	XLH (Initial): Prescribed by or in consultation with an endocrinologist or specialist experienced in the treatment of inborn errors of metabolism. TIO (Initial): Prescribed by or in consultation with an oncologist or endocrinologist.
Coverage Duration	XLH, TIO (Initial, Reauth): 12 months.
Other Criteria	XLH, TIO (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CTEXLI (S)

Products Affected

- Ctexli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease). Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: a) Neurologist, b) Geneticist, c) Metabolic disease specialist, or d) Endocrinologist.
Coverage Duration	Initial: 12 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CUPRIMINE (S)

Products Affected

- Cuprimine CAPS 250MG
- Penicillamine CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: 1) Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration), 2) Diagnosis of cystinuria AND trial and failure, contraindication, or intolerance to Thiola (tiopronin), or 3) Diagnosis of severe active rheumatoid arthritis AND patient has been unresponsive to conventional therapy (e.g., traditional DMARDs [e.g., methotrexate, sulfasalazine], TNF inhibitor [e.g., adalimumab, Enbrel (etanercept)], Non-TNF biologic [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CUVPOSA (S)

Products Affected

- Cuvposa
- Glycopyrrolate ORAL SOLN 1MG/5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic severe drooling (sialorrhea). Diagnosis of a neurologic condition (e.g., cerebral palsy) associated with chronic severe drooling (sialorrhea).
Age Restrictions	Initial: Patient is between 3 and 16 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy (e.g., reduction in drooling severity compared to baseline).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CUVRIOR (S)

Products Affected

- Cuvrior

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CYCLOBENZAPRINE (S)

Products Affected

- Amrix
- Cyclobenzaprine Hydrochloride TABS
- Cyclobenzaprine Hydrochloride Er
- Fexmid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient. Muscle spasm: Diagnosis of muscle spasm associated with acute, painful musculoskeletal conditions. Fibromyalgia (off-label): Used to treat fibromyalgia related symptoms (e.g., difficulty sleeping). Acute temporomandibular disorder (off-label): All of the following: a) Diagnosis of acute temporomandibular disorder, b) Patient has pain on palpitation of the lower jaw muscle, and c) Used in combination with a nonsteroidal anti-inflammatory drug (NSAID) (e.g., naproxen).
Age Restrictions	PA applies to patients 65 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Muscle spasm, temporomandibular disorder: 4 weeks. Fibromyalgia: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CYRAMZA (S)

Products Affected

- Cyramza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CYTOGAM (S)

Products Affected

- Cytogam INJ 50MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) the patient requires prophylaxis for CMV infection following kidney transplantation and the patient is CMV-seronegative and organ donor is CMV-seropositive, OR 2) Both of the following: a) the patient requires prophylaxis for CMV infection following liver, heart, lung, or pancreas transplantation, and the patient is CMV- seronegative and organ donor is CMV-seropositive AND b) the patient will receive concomitant therapy with ganciclovir or valganciclovir unless patient has a hypersensitivity or intolerance, or therapy is deemed inappropriate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

D.H.E. 45 (S)

Products Affected

- Dihydroergotamine Mesylate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Migraines (initial): Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: 1) Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or 2) contraindication to all triptans. Cluster Headaches (CH) (initial): Diagnosis of cluster headache. Trial and failure, contraindication, or intolerance to sumatriptan injection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Migraines, CH (initial, reauth): 12 months.
Other Criteria	Migraines (reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). CH (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DALIRESP (S)

Products Affected

- Daliresp
- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD) (initial): Diagnosis of COPD. History of COPD exacerbations which required the use of systemic corticosteroids, antibiotics, or hospital admission. Trial and failure, intolerance, or contraindication to two prior therapies for COPD (e.g., Combivent, Spiriva).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COPD (init, reauth): 12 months
Other Criteria	COPD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DANYELZA (S)

Products Affected

- Danyelza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DANZITEN (S)

Products Affected

- Danziten

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DARAPRIM (S)

Products Affected

- Daraprim
- Pyrimethamine TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Toxoplasmosis: 1) Patient is using pyrimethamine for the active treatment of toxoplasmosis (e.g., toxoplasmic encephalitis, ocular toxoplasmosis), secondary prophylaxis of toxoplasmosis, or treatment of congenital toxoplasmosis OR 2) Patient is using pyrimethamine for the primary prophylaxis of toxoplasmosis, patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX), and one of the following: patient has been re-challenged with TMP-SMX using a desensitization protocol and is still unable to tolerate, or evidence of life-threatening reaction to TMP-SMX in the past (eg, toxic epidermal necrolysis, Stevens-Johnson syndrome). Malaria: Requests for coverage of any pyrimethamine products for the treatment and/or prophylaxis of malaria are not authorized and will not be approved. The use of pyrimethamine for the treatment and/or prophylaxis of malaria is not recommended by the Centers for Disease Control and Prevention (CDC).
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasmosis: Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Toxoplasmosis: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DARZALEX (S)

Products Affected

- Darzalex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DARZALEX FASPRO (S)

Products Affected

- Darzalex Faspro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DATROWAY (S)

Products Affected

- Datroway

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAURISMO (S)

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute myeloid leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND Used in combination with low-dose cytarabine AND One of the following: 1) Patient is greater than or equal to 75 years old, or 2) Patient has comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAWNZERA (S)

Products Affected

- Dawnzera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 12 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAYBUE (S)

Products Affected

- Daybue
- Daybue Stix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Rett syndrome. One of the following: 1) Presence of ALL of the following clinical signs and symptoms: a) A pattern of development, regression, then recovery or stabilization, b) Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose, c) Partial or complete loss of spoken language, d) Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing, or e) Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait, OR 2) Molecular genetic testing confirms mutations in the MECP2 gene.
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a geneticist or neurologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAYVIGO (S)

Products Affected

- Dayvigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of insomnia. Trial and failure, contraindication, or intolerance to Belsomra (suvorexant). One of the following: a) Patient is 65 years of age or older OR b) Both of the following: Patient is less than 65 years or age AND trial and failure, contraindication, or intolerance to one of the following: eszopiclone, temazepam, zaleplon, zolpidem, zolpidem ER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DECNUPAZ (S)

Products Affected

- Decnupaz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DEFERASIROX (S)

Products Affected

- Deferasirox
- Exjade
- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.
Age Restrictions	Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
Other Criteria	Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DEMSER (S)

Products Affected

- Demser
- Metyrosine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to both of the following: a) alpha-adrenergic blocker (e.g., phenoxybenzamine, doxazosin, terazosin) AND b) beta-adrenergic blocker (e.g., propranolol, metoprolol). Treatment of pheochromocytoma (initial): Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Patient with hormonally active (catecholamine excess) pheochromocytoma. One of the following: a) patient is not a candidate for surgery OR b) chronic treatment due to malignant pheochromocytoma. Patient has not reached normotension after treatment with a selective alpha-1-adrenergic blocker (e.g., doxazosin, terazosin) and beta-adrenergic blocker (e.g., propranolol, metoprolol). Medication will not be used to control essential hypertension.
Age Restrictions	N/A
Prescriber Restrictions	Preop prep: Prescribed by or in consultation with an endocrinologist OR Endocrine surgeon. Pheochromocytoma (initial): Prescribed by or in consultation with endocrinologist OR provider who specializes in the management of pheochromocytoma.
Coverage Duration	Preop prep: 4 wks. Treatment of pheo (initial): 6 months, (reauth): 12 months.
Other Criteria	Treatment of pheochromocytoma (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased frequency and severity of hypertensive attacks).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DESMODA (S)

Products Affected

- Desmoda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of central diabetes insipidus (also known as arginine vasopressin deficiency). One of the following: 1) Intolerance to generic desmopressin tablet or spray, 2) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), or 3) Dosage requirements cannot be met with a solid dosage form.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DESOXYN (S)

Products Affected

- Desoxyn
- Methamphetamine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD).
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DEXLYT (S)

Products Affected

- Dexlyt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Requested drug is FDA-approved for the condition being treated. Both of the following: 1) Trial and intolerance to one alternative generic formulary dexamethasone formulation (e.g., dexamethasone 0.5 mg/mL oral solution, dexamethasone 1 mg tablet) within the previous 365 days AND 2) Submission of medical records (e.g., chart notes) confirming the trialed alternative formulary dexamethasone product has not been effective. Both of the following: 1) Trial and failure, contraindication, or intolerance to one generic formulary glucocorticoid (e.g., prednisone, methylprednisolone) at a dose that provides equivalent anti-inflammatory activity to Dexlyt within the previous 365 days AND 2) Both of the following: a) Submission of medical records (e.g., chart notes) confirming the trialed alternative formulary glucocorticoid at a dose with equivalent anti-inflammatory activity to Dexlyt has not been effective AND b) Valid clinical rationale provided for why Dexlyt is expected to provide benefit when the trialed alternative formulary glucocorticoid at a dose with equivalent anti-inflammatory activity to Dexlyt has not been shown to be effective (e.g., allergy to excipient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DIACOMIT (S)

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with clobazam. Patient weighs 7kg or more.
Age Restrictions	Patient is 6 months of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DIBENZYLINE (S)

Products Affected

- Dibenzyline
- Phenoxybenzamine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to one of the following: a) doxazosin, or b) prazosin.
Age Restrictions	N/A
Prescriber Restrictions	Preop prep: prescribed by or in consultation with an endocrinologist or endocrine surgeon.
Coverage Duration	4 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DOJOLVI (S)

Products Affected

- Dojolvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Long-Chain Fatty Acid Oxidation Disorder (LC-FAOD) (initial): Diagnosis of a LC-FAOD has been confirmed by at least two of the following: a) Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma, b) Low enzyme activity in cultured fibroblasts, or c) One or more known pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB. Not used with any other medium-chain triglyceride (MCT) product.
Age Restrictions	N/A
Prescriber Restrictions	LC-FAOD (initial, reauth): Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.).
Coverage Duration	LC-FAOD (initial, reauth): 12 months
Other Criteria	LC-FAOD (reauth): Prescriber attests to continued need of therapy. Not used with any other medium-chain triglyceride (MCT) product.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DOPTELET (S)

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Patient has chronic liver disease and is scheduled to undergo a procedure. Baseline platelet count is less than 50,000/mcL. Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic ITP, relapsed/refractory ITP, or pediatric patient with persistent ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	TPPP: 1 month. ITP (initial, reauth): 12 months
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DOPTELET SPRINKLE (S)

Products Affected

- Doptelet Sprinkle

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic ITP, relapsed/refractory ITP, or pediatric patient with persistent ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP (initial, reauth): 12 months
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DOXEPIN TOPICAL (S)

Products Affected

- Doxepin Hydrochloride CREA
- Prudoxin
- Zonalon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of moderate pruritus. Patient has atopic dermatitis or lichen simplex chronicus. Trial and failure, contraindication, or intolerance to at least one medium potency topical corticosteroid, or is not a candidate for topical corticosteroids (e.g., treatment is on face, axilla, or groin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUEXIS (S)

Products Affected

- Duexis
- Ibuprofen/famotidine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Osteoarthritis or rheumatoid arthritis (initial): Diagnosis of osteoarthritis or rheumatoid arthritis. One of the following: a) history of peptic ulcer disease, b) history of gastrointestinal (GI) bleeding, obstruction, or perforation, c) erosive esophagitis, or d) used in combination with aspirin. Trial and failure, contraindication or intolerance to both generic ibuprofen tablet and generic famotidine tablet.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 6 months.
Other Criteria	Osteoarthritis or rheumatoid arthritis (Reauthorization): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DULERA (S)

Products Affected

- Dulera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (initial): Diagnosis of asthma. Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age), or intolerance to Breo Ellipta (fluticasone furoate and vilanterol trifenatate).
Age Restrictions	Initial: Patient is 5 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Asthma (reauthorization): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUOBRII (S)

Products Affected

- Duobrii

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque Psoriasis: Diagnosis of plaque psoriasis. Both of the following: 1) Trial and failure, intolerance or contraindication to one high potency corticosteroid topical treatment (e.g., halobetasol propionate, clobetasol propionate, fluocinonide) AND 2) Trial and failure or intolerance to tazarotene.
Age Restrictions	N/A
Prescriber Restrictions	Plaque Psoriasis: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plaque Psoriasis: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUOPA (S)

Products Affected

- Duopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of PD. Patient is levodopa-responsive and experiences disabling "Off" periods for a minimum of 3 hours/day. Disabling "Off" periods occur despite therapy with both of the following: a) oral levodopa-carbidopa and b) one drug from a different class of anti-Parkinson's disease therapy (eg, COMT inhibitor [entacapone, tolcapone], MAO-B inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole]).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	Subject to Part B vs. Part D review. PD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DUPIXENT (S)

Products Affected

- Dupixent INJ 200MG/1.14ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-tx) peripheral blood eosinophil level greater than or equal to 150 cells/ml. One of the following: 1) Pt has had 2 or more asthma exacerbations requiring systemic corticosteroids (CS) (eg, prednisone) w/in the past 12 mo, 2) Prior asthma-related hospitalization w/in the past 12 mo. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Pt is currently dependent on oral CS for the treatment of asthma. EA, CDA (init): One of the following: 1) Both of the following: a) Pt is at least 6 yo but less than 12 yo b) Pt is currently being treated w/ 1 of the following unless there is a contraindication or intolerance (C/I) to these meds: i) Medium-dose inhaled corticosteroid (ICS) (eg, greater than 100–200mcg fluticasone propionate equivalent/day) and Additional asthma controller med (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) or ii) 1 medium dosed combo ICS/LABA product (eg, fluticasone propionate 100mcg/salmeterol50mcg, budesonide80mcg/formoterol4.5mcg, fluticasone furoate 50mcg/vilanterol 25mcg) OR 2) Pt is at least 12 yo and Pt is currently being treated w/ 1 of the following unless there is a C/I to these meds: a) Both of the following: i) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller med, OR b) 1 maximally-dosed combo ICS/LABA product [eg, fluticasone propionate 500mcg/salmeterol50mcg, budesonide160mcg/formoterol4.5mcg, fluticasone200mcg/vilanterol25mcg]. Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Dx of CRSwNP. Unless contraindicated, the pt has had an inadequate response to 2 mo of tx with an intranasal CS (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP.

Age Restrictions	AD (initial): Patient is 6 months or age or older. CRSwNP, PN: no age restriction. EoE (initial): Patient is at least 1 year of age.
Prescriber Restrictions	AD, PN, CSU, BP (Init): Prescribed/consult with a dermatologist or allergist/immunologist. Asthma (init): Prescribed/consult with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed/consult with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (init): Prescribed/consult with a gastroenterologist or allergist/immunologist. AFRS (init): Prescribed/consult with an otolaryngologist, allergist/immunologist, or pulmonologist.
Coverage Duration	AFRS, CRSwNP, EoE (Init/Reauth): 12 mo. Asthma, AD, PN, COPD, CSU, BP (Init): 6 mo, (reauth): 12 mo.

Other Criteria	Eosinophilic esophagitis (EoE) (init): Dx of EoE. Pt has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, GERD/heartburn symptoms, chest pain, abdominal pain). Pt has at least 15 intraepithelial eosinophils per high power field. Other causes of esophageal eosinophilia have been excluded. Pt weighs at least 15 kg. Trial and failure, contraindication, or intolerance (TF/C/I) to at least an 8-wk trial of 1 of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) CS (eg, budesonide, fluticasone). PN (init): Dx of PN. Atopic dermatitis (AD) (init): Dx of mod to severe AD. 1 of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing AD (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for TCS), CI (eg, safety concerns, not indicated for pt's age/wt), or intol to 1 of the following: a) Medium or higher potency TCS, b) Pimecrolimus, c) Tacrolimus ointment, or d) crisaborole. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of type 2 inflammation evidenced by baseline blood eosinophils greater than or equal to 300 cells/mcL. Pt is receiving 1 of the following at maximally tolerated doses: triple therapy [ie, an ICS, a LAMA, and a LABA] OR if CI to ICS, a LAMA and a LABA. Pt has had at least 2 exacerbations where systemic CS [IM/IV/oral] were required at least once OR COPD-related hospitalization w/in the past 12 mo. Bullous Pemphigoid (BP) (init): Dx of BP as confirmed by skin biopsy or serology. Will be used in combo w/ a tapering course of oral CS until disease control has occurred. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction in BSA involvement or SCORAD index value from baseline. AFRS, EA, CDA, PN, CRSwNP, COPD, BP (reauth): Pt demonstrates positive clinical response to therapy. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement of 1 of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures). COPD (reauth): Pt cont on triple therapy (ie, an ICS, a LAMA, and a LABA) OR if CI to ICS, a LAMA and a LABA. Chronic Spontaneous Urticaria (CSU) (init): Dx of CSU. Persistent symptoms (itching and hives) with a 2nd generation H1 antihistamine (H1A) (eg, cetirizine, fexofenadine), unless C/I to H1A. Used concurrently with an H1A unless C/I to H1A. CSU (reauth): Pt demonstrates positive clinical response to therapy as evidenced by a reduction from baseline in itching severity or number of hives. Allergic Fungal Rhinosinusitis (AFRS) (init): Dx of AFRS. Pt has history of sino-nasal surgery.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUVYZAT (S)

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Duchenne muscular dystrophy (DMD). One of the following: A) Patient has a confirmed mutation of the dystrophin gene, or B) Muscle biopsy confirmed an absence of dystrophin protein. Patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to initiating Duvyzat.
Age Restrictions	Initial: Patient is 6 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a benefit from therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DYSPORT (S)

Products Affected

- Dysport

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (initial): Diagnosis of CD (also known as spasmodic torticollis). Spasticity (initial): Diagnosis of spasticity.
Age Restrictions	Spasticity (initial): Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	CD, Spasticity (initial): 3 months, (reauth): 12 months.
Other Criteria	CD, Spasticity (reauth): Patient demonstrates positive clinical response to therapy. At least 3 months have elapsed since the last treatment.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EBGLYSS 2 (S)

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe atopic dermatitis. Patient weighs at least 40 kg. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) crisaborole ointment.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EGRIFTA (S)

Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HIV-associated lipodystrophy (initial): All of the following: 1) diagnosis of HIV-associated lipodystrophy, 2) one of the following: a) waist-circumference of greater than or equal to 95 cm (37.4 inches) in men, OR b) waist-circumference of greater than or equal to 94 cm (37 inches) for women, 3) one of the following: a) Waist-to-hip ratio of greater than or equal to 0.94 for men, OR b) waist-to-hip ratio of greater than or equal to 0.88 for women, 4) body mass index (BMI) greater than 20 kg/m^2, AND 5) fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L), AND 6) patient has been on a stable regimen of antiretrovirals (eg, nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	(reauth): Patient demonstrates clinical improvement (eg, improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc) while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EGRIFTA WR (S)

Products Affected

- Egrifta Wr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of HIV-associated lipodystrophy. One of the following: a) waist-circumference of greater than or equal to 95 cm (37.4 inches) in men, OR b) waist-circumference of greater than or equal to 94 cm (37 inches) for women. One of the following: a) Waist-to-hip ratio of greater than or equal to 0.94 for men, OR b) waist-to-hip ratio of greater than or equal to 0.88 for women. Body mass index (BMI) greater than 20 kg/m^2. Fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L). Patient has been on a stable regimen of antiretrovirals (e.g., nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors, integrase inhibitors) for at least 8 weeks.
Age Restrictions	Initial: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc.).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EKTERLY (S)

Products Affected

- Ekterly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 12 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELAHERE (S)

Products Affected

- Elahere

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELAPRASE (S)

Products Affected

- Elaprase

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Hunter Syndrome (Mucopolysaccharidosis II (MPS II))
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELELYSO (S)

Products Affected

- Elelyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	Gaucher disease: Patient is 4 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELFABRIO (S)

Products Affected

- Elfabrio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Fabry disease. Disease confirmed by one of the following: 1) Detection of pathogenic mutations in the GLA gene by molecular genetic testing, 2) Deficiency in alpha-galactosidase A (alpha-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS), or 3) Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata). Will not be used in combination with other drugs used for Fabry disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Will not be used in combination with other drugs used for Fabry disease.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELIGARD (S)

Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ELREXFIO (S)

Products Affected

- Elrexfio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ELYXYB (S)

Products Affected

- Elyxyb

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of migraine with or without aura. Trial and failure, contraindication, or intolerance to two generic nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ELZONRIS (S)

Products Affected

- Elzonris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMCITATE (S)

Products Affected

- Emcitate

PA Criteria	Criteria Details
Indications	N/A
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A
Prerequisite Therapy Required	

EMFLAZA (S)

Products Affected

- Deflazacort
- Emflaza
- Jaythari SUSP
- Kymbee
- Pyquvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of Duchenne muscular dystrophy (DMD). Patient has received genetic testing for a mutation of the dystrophin gene. Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following: A) Documentation of a confirmed mutation of the dystrophin gene or B) Muscle biopsy confirmed an absence of dystrophin protein. Patient has had a trial and failure or intolerance to prednisone or prednisolone.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EMGALITY (S)

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (120 mg/mL strength only) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (120 mg strength/mL only) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. Episodic Cluster Headache (ECH) (100 mg/mL strength only) (initial): Diagnosis of episodic cluster headache. Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months. Medication will not be used in combination with another injectable CGRP inhibitor. EM, CM (120 mg/mL strength only) (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM, ECH (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. ECH (initial): 3 months. EM, CM, ECH (reauth): 12 months.

Other Criteria	EM, CM (120 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (120 mg/mL strength only) (reauth): Patient continues to be monitored for medication overuse headache. ECH (100 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy. Medication will not be used in combination with another injectable CGRP inhibitor.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMPAVELI (S)

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH. Complement 3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN) (initial): Diagnosis of C3G or primary IC-MPGN. For primary IC-MPGN, patient has not had a kidney transplant. Used to reduce proteinuria. Patient is currently being treated with a maximally tolerated dose of one of the following for at least 12 weeks prior to initiating treatment: 1) Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril), 2) Angiotensin receptor blockers (e.g., losartan, valsartan), or 3) Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
Age Restrictions	C3G, Primary IC-MPGN (initial): Patient is 12 years of age or older.
Prescriber Restrictions	PNH (initial): Prescribed by or in consultation with a hematologist or oncologist. C3G, Primary IC-MPGN (initial): Prescribed by or in consultation with a nephrologist.
Coverage Duration	PNH, C3G, Primary IC-MPGN (initial, reauth): 12 months.
Other Criteria	PNH (reauth): Patient demonstrates positive clinical response to therapy. C3G, Primary IC-MPGN (reauth): Patient demonstrates positive clinical response to therapy. For primary IC-MPGN, patient has not had a kidney transplant. Patient continues to be treated with a maximally tolerated dose of one of the following: 1) Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril), 2) Angiotensin receptor blockers (e.g., losartan, valsartan), or 3) Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EMPLICITI (S)

Products Affected

- Empliciti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENBREL (S)

Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.

Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENBUMYST (S)

Products Affected

- Enbumyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of edema associated with congestive heart failure, hepatic disease, renal disease, or nephrotic syndrome. Used for short-term treatment when the use of IV or oral bumetanide is not feasible (e.g., access issues, resistance, poor gastrointestinal absorption, delayed onset).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENDARI (S)

Products Affected

- Endari
- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. Patient has had 2 or more painful sickle cell crises within the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Sickle cell disease (initial, reauth): 12 months
Other Criteria	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENHERTU (S)

Products Affected

- Enhertu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENJAYMO (S)

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cold agglutinin disease (CAD) based on all of the following: a) Presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count), b) Positive polyspecific direct antiglobulin test (DAT), c) Monospecific DAT strongly positive for C3d, d) Cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius, and e) Direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1+ or less. Patient does not have cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders). Baseline hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL). One of the following: a) Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg OR b) Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENSACOVE (S)

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) Locally advanced or b) Metastatic. Disease is anaplastic lymphoma kinase (ALK) rearrangement-positive as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has not previously received an ALK-inhibitor [e.g., Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), Xalkori (crizotinib), Zykadia (ceritinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENSPRYNG (S)

Products Affected

- Enspryng

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive.
Age Restrictions	N/A
Prescriber Restrictions	NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist.
Coverage Duration	NMOSD (initial, reauth): 12 months
Other Criteria	NMOSD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENTYVIO IV (S)

Products Affected

- Entyvio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ulcerative Colitis (UC) (init): Diagnosis (Dx) of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: one formulary adalimumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Crohn's Disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to two of the following: one formulary adalimumab product, Rinvoq, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), or one formulary ustekinumab product, OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC, CD (init): 14 weeks. UC, CD (reauth): 12 months.
Other Criteria	UC, CD (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENTYVIO SC (S)

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. CD, UC (initial): One of the following: a) Will be used as a maintenance dose following two doses of Entyvio IV for induction, or b) Patient is currently established on Entyvio IV.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 14 weeks. CD, UC (reauth): 12 months.
Other Criteria	CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENZEEVU (S)

Products Affected

- Enzeevu

PA Criteria	Criteria Details
Indications	N/A
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A
Prerequisite Therapy Required	

EOHILIA (S)

Products Affected

- Eohilia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of eosinophilic esophagitis (EoE). Patient has symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, heartburn, abdominal pain). Patient has at least 15 intraepithelial eosinophils per high power field (HPF). Other causes of esophageal eosinophilia have been excluded. One of the following: a) trial and failure (of a minimum 8-week duration), contraindication, or intolerance to a proton pump inhibitor (e.g., pantoprazole, omeprazole), or b) trial and failure (of a minimum 8-week duration), or intolerance to a topical (esophageal) corticosteroid (e.g., budesonide, fluticasone).
Age Restrictions	Patient is 11 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with one of the following: allergist/immunologist or gastroenterologist.
Coverage Duration	12 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPCLUSA NON-PREFERRED (S)

Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. One of the following: 1) Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to Mavyret (except patients with decompensated cirrhosis) AND sofosbuvir/velpatasvir, OR 2) For continuation of prior therapy. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
Age Restrictions	N/A
Prescriber Restrictions	One of the following: 1) Patient is treatment-naïve without decompensation, or 2) Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPCLUSA PREFERRED (S)

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist. Prescriber requirement does not apply for patient who is Hepatitis C treatment naive without decompensation.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPIDIOLEX (S)

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC.
Age Restrictions	LGS, DS, TSC: Patient is 1 year of age or older.
Prescriber Restrictions	LGS, DS, TSC: Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPKINLY (S)

Products Affected

- Epkinly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPOETIN ALFA (S)

Products Affected

- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Procrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial):Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon/peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa. Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 months is 33% or less (Hgb is 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Adequate iron stores confirmed by both of the following: a) Patient's ferritin level is greater than 100 mcg/L and b) Patient's transferrin saturation (TSAT) is greater than 20%.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPOPROSTENOL (S)

Products Affected

- Epoprostenol Sodium
- Flolan
- Veletri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. (Reauth): 12 months
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPSOLAY (S)

Products Affected

- Epsolay

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of rosacea. Patient has inflammatory lesions. Trial and failure (of a minimum 30-day supply), contraindication, or intolerance to one formulary topical product for rosacea (e.g., azelaic acid gel, metronidazole cream or gel).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERBITUX (S)

Products Affected

- Erbitux

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERIVEDGE (S)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Basal cell carcinoma: One of the following: A) Diagnosis of metastatic basal cell carcinoma OR B) Both of the following: 1) Diagnosis of locally advanced basal cell carcinoma AND 2) One of the following: a) Disease recurred following surgery or b) Patient is not a candidate for surgery and radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERLEADA (S)

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ESBRIET (S)

Products Affected

- Esbriet
- Pirfenidone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF.
Age Restrictions	N/A
Prescriber Restrictions	IPF (initial): Prescribed by or in consultation with a pulmonologist
Coverage Duration	initial, reauth: 12 months
Other Criteria	IPF (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EUCRISA (S)

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Atopic dermatitis (initial): Diagnosis of mild to moderate atopic dermatitis. Trial and failure, contraindication, or intolerance to one prescription strength topical corticosteroid (e.g., triamcinolone acetonide, fluocinolone acetonide), unless the affected area is sensitive (i.e., face, axillae, groin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVDI (S)

Products Affected

- Evdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EVENITY (S)

Products Affected

- Evenity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of postmenopausal osteoporosis. One of the following: A) History of a low-trauma (fragility) fracture of a major osteoporotic site (e.g., hip, spine, proximal humerus, pelvis, or distal forearm), B) Bone mineral density (BMD) T-score of -3.0 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site), C) Both of the following: 1) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) with no history of fracture AND 2) Trial and failure, contraindication, or intolerance (TF/C/I) to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), OR D) All of the following: 1) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site), 2) One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, AND 3) TF/C/I to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]). Trial of, contraindication, or intolerance to one of the following: Forteo (teriparatide) or Tymlos (abaloparatide). Treatment duration of Evenity (romosozumab-aqqg) has not exceeded a total of 12 months during the patient's lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months (max 12 months of therapy per lifetime)
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVKEEZA (S)

Products Affected

- Evkeeza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Homozygous Familial Hypercholesterolemia (HoFH) (initial): Diagnosis of HoFH as confirmed by one of the following: A) Genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, or B) Untreated LDL-C greater than 400 mg/dL, AND either xanthoma before 10 years of age or evidence of heterozygous familial hypercholesterolemia in both parents. One of the following: A) Patient is currently treated with maximally tolerated statin therapy, B) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR C) Patient has a contraindication to all statins. One of the following: A) Patient has been receiving ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy, B) Patient has a history of contraindication or intolerance to ezetimibe, OR C) Patient is less than 10 years of age. One of the following: A) Patient has been treated w/ PCSK9 therapy or did not respond to PCSK9 therapy, B) Physician attests that the patient is known to have 2 LDL-receptor negative alleles (little to no residual function) and therefore would not respond to PCSK9 therapy, C) Patient has a history of intolerance or contraindication to PCSK9 therapy, OR D) Patient is less than 10 years of age. Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza. Dose will not exceed 15 mg/kg of bodyweight infused once every 4 weeks.
Age Restrictions	HoFH (initial): Patient is 1 year of age or older.
Prescriber Restrictions	HoFH (initial): Prescribed by or in consultation with a cardiologist, endocrinologist, or hepatologist.
Coverage Duration	HoFH (initial, reauth): 12 months.

Other Criteria	HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by LDL-C reduction from baseline. Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza. Dose will not exceed 15 mg/kg of bodyweight infused once every 4 weeks.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVRYSDI (S)

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on both of the following: 1) Invasive ventilation or tracheostomy and 2) Use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Revised Upper Limb Module (RULM) Test (Non ambulatory), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Motor Function Measure 32 (MFM-32) Scale, or Item 22 of the Bayley Scales of Infant and Toddler Development Third Edition (BSID-III). Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
Age Restrictions	N/A
Prescriber Restrictions	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

Coverage Duration	Initial, Reauth: 12 months
Other Criteria	SMA (Reauth): Patient demonstrates positive clinical response to therapy. Pt is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) pt has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) pt has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EXONDYS 51 (S)

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following: a) diagnosis of Duchenne muscular dystrophy (DMD) and b) patient has a mutation of the dystrophin gene amenable to exon 51 skipping. Dose will not exceed 30 mg/kg of body weight infused once weekly. Submission of medical records (e.g., chart notes, laboratory values) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: Patient is tolerating therapy, dose will not exceed 30 mg/kg of body weight infused once weekly, and submission of medical records (e.g., chart notes, laboratory values) confirming the patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EXSERVAN (S)

Products Affected

- Exservan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Diagnosis of ALS. Trial and failure or intolerance to generic riluzole tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EYLEA (S)

Products Affected

- Eylea

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Retinopathy of Prematurity (ROP) (initial): Diagnosis of ROP. One of the following: a) Patient gestational age at birth less than or equal to 32 weeks, OR b) Patient birth weight less than or equal to 1500 grams. Patient weight greater than 800 grams on day of treatment. ROP is present in at least one eye with one of the following classifications: a) ROP zone 1, stage 1 plus, 2 plus, 3, or 3 plus, b) ROP zone 2, stage 2 plus or 3 plus, OR c) AP-ROP (aggressive posterior ROP). All indications except ROP (initial): One of the following diagnoses: A) Neovascular (wet) age-related macular degeneration OR B) Macular edema following retinal vein occlusion, OR C) Diabetic macular edema OR D) Diabetic retinopathy. Trial and failure, contraindication, or intolerance to compounded bevacizumab prepared by a 503(B) Outsourcing Facility OR Lucentis (ranibizumab).
Age Restrictions	N/A
Prescriber Restrictions	All indications except ROP (initial): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases. ROP (initial, reauth): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	All indications (initial, reauth): 12 months
Other Criteria	All indications (reauth): Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FABHALTA (S)

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal nocturnal hemoglobinuria (PNH) (Initial): Diagnosis of PNH. Immunoglobulin A nephropathy (IgAN) (Initial): Diagnosis of primary IgAN. Patient is at risk of rapid disease progression. Used to slow kidney function decline. Patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following: a) An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), OR b) An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan). Complement 3 Glomerulopathy (C3G) (Initial): Diagnosis of kidney complement 3 glomerulopathy (C3G). Used to reduce proteinuria. Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan).
Age Restrictions	N/A
Prescriber Restrictions	PNH (Initial): Prescribed by or in consultation with a hematologist/oncologist. IgAN, C3G (Initial): Prescribed by or in consultation with a nephrologist.
Coverage Duration	All Indications (Initial, Reauth): 12 months
Other Criteria	All Indications (Reauth): Patient demonstrates positive clinical response to therapy. C3G (Reauth): Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FABRAZYME (S)

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fabry Disease (init): Diagnosis of Fabry disease. One of the following: a) detection of pathogenic mutations in the GLA gene by molecular genetic testing, b) deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS), or c) significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata). Will not be used in combination with other drugs used for Fabry disease.
Age Restrictions	Fabry Disease (init): Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Fabry Disease (init, reauth): 12 months
Other Criteria	Fabry Disease (reauth): Patient demonstrates positive clinical response to therapy. Will not be used in combination with other drugs used for Fabry disease.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FASENRA (S)

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR 2) Prior asthma-related hospitalization within the past 12 months. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (e.g., greater than 100-200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) or ii) One medium dosed combination ICS/LABA product (e.g., Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/ formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [e.g., Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].

Age Restrictions	N/A
Prescriber Restrictions	Asthma (initial): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. EGPA (initial): Prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist. HES (initial): Prescribed by or in consultation with an allergist/immunologist or hematologist.
Coverage Duration	Asthma (init): 6 months. Asthma (reauth): 12 months. EGPA, HES (init/reauth): 12 months.
Other Criteria	Eosinophilic granulomatosis with polyangiitis (EGPA) (initial): Diagnosis of EGPA. Patient is currently receiving corticosteroid therapy (eg, prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy. Hypereosinophilic Syndrome (HES) (initial): Diagnosis of HES. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is Fip1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA)-negative. Patient has pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication, or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). Asthma, EGPA, HES (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FENSOLVI (S)

Products Affected

- Fensolvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range. Trial and failure or intolerance to Lupron Depot-Ped.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FENTANYL (S)

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, Oral hydrocodone at a dose of greater than or equal to 60 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FERRIPROX (S)

Products Affected

- Deferiprone
- Ferriprox
- Ferriprox Twice-a-day

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transfusional iron overload (Initial): Diagnosis of transfusional iron overload due to one of the following: thalassemia syndromes, sickle cell disease, or other transfusion-dependent anemias. Patient has Absolute Neutrophil Count (ANC) greater than 1.5 x 10^9/L. Trial and failure, contraindication or intolerance to one chelation therapy (e.g., generic deferasirox).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy. ANC greater than 1.5 x 10^9/L.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FILSPARI (S)

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN) (Initial): Diagnosis of IgAN. Patient is at risk for disease progression. Used to slow kidney function decline. One of the following: 1) Patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following: a) An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), OR b) An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to both ACE inhibitors and ARBs. Medication will not be used in combination with any of the following: a) Angiotensin receptor blockers, b) Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)], and c) Tekturna (aliskiren). Focal Segmental Glomerulosclerosis (FSGS) (Initial): Diagnosis of FSGS. Used to reduce proteinuria. Patient does not have nephrotic syndrome. Medication will not be used in combination with any of the following: a) Angiotensin receptor blockers, b) Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)], and c) Tekturna (aliskiren).
Age Restrictions	FSGS (Initial): Patient is 8 years of age or older.
Prescriber Restrictions	All Indications (Initial): Prescribed by or in consultation with a nephrologist.
Coverage Duration	All Indications: (Initial, Reauth): 12 months
Other Criteria	All Indications (Reauth): Patient demonstrates positive clinical response to therapy. Medication is not taken in combination with any of the following: a) Angiotensin receptor blockers, b) Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)], and c) Tekturna (aliskiren).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FILSUVEZ (S)

Products Affected

- Filsuvez

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of one of the following: 1) dystrophic epidermolysis bullosa (DEB), or 2) junctional epidermolysis bullosa (JEB). Medication is being used for the treatment of wounds that require healing. Target wound(s) has no signs of infection. Medication is not being used concurrently with other FDA approved therapies (e.g., Vyjuvek) on the same target wound for the treatment of epidermolysis bullosa.
Age Restrictions	Initial: Patient is 6 months of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a dermatologist or specialist with expertise in wound care.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Wound(s) being treated continues to have no signs of infection. Medication is not being used concurrently with other FDA approved therapies (e.g., Vyjuvek) on the same target wound for the treatment epidermolysis bullosa.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FINTEPLA (S)

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dravet Syndrome: Diagnosis of seizures associated with Dravet syndrome. Lennox-Gastaut Syndrome: Diagnosis of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	All Indications: Patient is 2 years of age or older.
Prescriber Restrictions	All Indications: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FIRAZYR (S)

Products Affected

- Firazyr
- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 18 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FIRDAPSE (S)

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS) (initial): Diagnosis of LEMS.
Age Restrictions	LEMS (initial): Patient is 6 years of age or older.
Prescriber Restrictions	LEMS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	LEMS (initial, reauth): 12 months.
Other Criteria	LEMS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FIRMAGON (S)

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FLECTOR (S)

Products Affected

- Diclofenac Epolamine
- Flector

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).
Required Medical Information	Pain: Diagnosis of acute, localized pain due to minor strains, sprains and contusions. Patient meets one of the following: 1) Treatment failure with at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen). OR 2) History of peptic ulcer disease/gastrointestinal bleed. OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FOLOTYN (S)

Products Affected

- Folotyn
- Pralatrexate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FORZINITY (S)

Products Affected

- Forzinity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Barth syndrome. Disease is confirmed by the presence of a mutation in the Tafazzin gene, as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient weight is greater than or equal to 30kg.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: geneticist, cardiologist, hematologist, neurologist, or specialist focused on the treatment of metabolic disorders.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FOTIVDA (S)

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced renal cell carcinoma. Disease is one of the following: relapsed or refractory. Patient has received two or more prior systemic therapies (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FRUZAQLA (S)

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI), and B) Anti-VEGF biological therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-afibercept]). One of the following: A) Patient has RAS mutant tumors, OR B) Both of the following: a) Patient has RAS wild-type tumors, AND b) Patient has been previously treated with both of the following: 1) An anti-EGFR biological therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), and 2) One of the following: i) Lonsurf [trifluridine/tipiracil] or ii) Stivarga [regorafenib].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FULPHILA (S)

Products Affected

- Fulphila

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta AND Udenyca.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FUROSCIX (S)

Products Affected

- Furoscix
- Furoscix Readyflow

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: A) chronic heart failure (CHF), or B) Chronic kidney disease (CKD) (e.g., nephrotic syndrome). Drug will be used for the treatment of edema. Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide). Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FYARRO (S)

Products Affected

- Fyarro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FYLNETRA (S)

Products Affected

- Fylnetra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	All Indications (except for ARS): Trial or intolerance to one of the following: Neulasta/Neulasta Onpro or Udenyca/Udenyca Onbody. ARS: Trial or intolerance to one of the following: Neulasta or Udenyca.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GALAFOLD (S)

Products Affected

- Galafold

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fabry Disease (FD) (initial): Diagnosis of FD. One of the following: a) detection of pathogenic mutations in the GLA gene by molecular genetic testing, b) deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS), or c) significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata). Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data. FD (initial, reauthorization): Will not be used in combination with other drugs used for Fabry disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	FD (initial, reauth): 12 months.
Other Criteria	FD (reauthorization): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GAMASTAN (S)

Products Affected

- Gamastan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune globulin is being used intramuscularly. The immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Patient requires immunization for hepatitis A, measles, rubella, or varicella.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GAMIFANT (S)

Products Affected

- Gamifant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Hemophagocytic Lymphohistiocytosis (HLH) (initial): Diagnosis of primary HLH. One of the following: 1) Disease is refractory, recurrent, or progressive, or 2) Trial and failure, contraindication, or intolerance to conventional HLH therapy (e.g., etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate). HLH (initial, reauth): Patient has not received hematopoietic stem cell transplantation (HSCT). HLH/Macrophage Activation Syndrome (MAS) in Still's disease (initial): Diagnosis of active HLH/MAS. Disease occurs in known or suspected Still's disease [e.g., systemic Juvenile Idiopathic Arthritis (sJIA), adult onset Still's disease (AOSD)]. One of the following: 1) Trial and failure, contraindication, or intolerance to high-dose corticosteroids (e.g., methylprednisolone, prednisone), or 2) Patient experiences recurrent MAS.
Age Restrictions	N/A
Prescriber Restrictions	Primary HLH (initial): Prescribed by or in consultation with a hematologist/oncologist. HLH/MAS in Still's disease (initial): Prescribed by or in consultation with a rheumatologist/hematologist.
Coverage Duration	Primary HLH, HLH/MAS in Still's disease (initial, reauth): 6 months.
Other Criteria	Primary HLH, HLH/MAS in Still's disease (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GATTEX (S)

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support.
Age Restrictions	SBS (initial): Patient is 1 year of age or older.
Prescriber Restrictions	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GAVRETO (S)

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Presence of metastatic rearranged during transfection (RET) gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Thyroid Cancer: Diagnosis of thyroid cancer. Disease is one of the following: advanced or metastatic. Disease has presence of rearranged during transfection (RET) gene fusion-positive tumor(s). Disease requires treatment with systemic therapy. One of the following: patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.
Age Restrictions	Thyroid Cancer: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GAZYVA (S)

Products Affected

- Gazyva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lupus Nephritis (LN): Diagnosis of active LN. Currently receiving standard of care treatment for active lupus nephritis (eg, corticosteroids [eg, prednisone] with mycophenolate or cyclophosphamide). Chronic Lymphocytic Leukemia (CLL), Follicular Lymphoma (FL): One of the following: A) Both of the following: 1) Prescribed medication is being used for one of the following FDA-approved indications: CLL, FL, and 2) Both of the following labeling requirements have been confirmed: a) All components of the FDA approved indication are met (eg, concomitant use, previous therapy requirements, age limitations, testing requirements, etc.), and b) Prescribed medication will be used at a dose which is within FDA recommendations, OR B) Meets the off-label administrative guideline criteria.
Age Restrictions	N/A
Prescriber Restrictions	LN: Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	All indications: 12 months
Other Criteria	All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GILENYA (S)

Products Affected

- Fingolimod Hydrochloride
- Gilenya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GILOTRIF (S)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): A) Diagnosis of advanced or metastatic (stage IIIB or IV) NSCLC AND B) One of the following: 1) Both of the following: a) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy (e.g., cisplatin, carboplatin) and b) squamous NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GIVLAARI (S)

Products Affected

- Givlaari

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of acute hepatic porphyria (i.e., acute intermittent porphyria, hereditary coproporphyria, variegate porphyria, ALA dehydrase deficient porphyria). Patient has active disease with at least two documented porphyria attacks within the past 6 months. Provider attestation documenting elevated urinary or plasma levels of one of the following within the past 12 months: 1) porphobilinogen (PBG) or 2) delta-aminolevulinic acid (ALA). Patient has not had a liver transplant.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with one of the following: a) gastroenterologist, b) hepatologist, c) hematologist, d) neurologist, or e) a specialist with expertise in the diagnosis and management of acute hepatic porphyria.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response while on therapy as demonstrated by both of the following: 1) Reduction in hemin administration requirements and 2) Reduction in the rate or number of porphyria attacks. Patient has not had a liver transplant.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLATIRAMER ACETATE (S)

Products Affected

- Copaxone INJ 20MG/ML, 40MG/ML
- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLEEVEC (S)

Products Affected

- Imatinib Mesylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+)/BCR ABL-positive chronic myelogenous leukemia (CML) OR B) Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease OR G) Aggressive systemic mastocytosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GLEEVEC BRAND (S)

Products Affected

- Gleevec TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+)/BCR ABL-positive chronic myelogenous leukemia (CML) OR B) Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease OR G) Aggressive systemic mastocytosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy. All uses: Trial and failure, or intolerance to generic imatinib.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GLUMETZA (S)

Products Affected

- Glumetza
- Metformin Hydrochloride Er TB24 1000MG, 500MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) AND documented history of an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by hemoglobin A1c level is above patient's goal OR b) Documented history of intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction). One of the following: a) History of greater than or equal to 12 week trial of metformin immediate-release AND documented history of an inadequate response to metformin immediate-release as evidenced by hemoglobin A1c level is above patient's goal OR b) documented history of intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GLYCOPYRROLATE TABLET (S)

Products Affected

- Glycate TABS 1.5MG
- Glycopyrrolate TABS
- Robinul TABS
- Robinul Forte

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial, Reauth: 3 months.
Other Criteria	Reauth: One of the following: 1) Patient's peptic ulcer has not healed, OR 2) Patient has a new peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine). Patient experienced a reduction in peptic ulcer symptoms while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GOCOVRI (S)

Products Affected

- Gocovri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyskinesia in Parkinson's disease (PD) (initial): Diagnosis of Parkinson's disease, patient is experiencing dyskinesia, patient is receiving levodopa-based therapy. "Off" Episodes in Parkinson's disease (initial): Diagnosis of Parkinson's disease. Patient is experiencing "off" episodes. Used in combination with levodopa/carbidopa therapy.
Age Restrictions	N/A
Prescriber Restrictions	All Indications (Initial): Prescribed by or in consultation with a neurologist
Coverage Duration	All Indications (initial, reauth): 12 months
Other Criteria	All Indications (reauthorization): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GOMEKLI (S)

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of neurofibromatosis type 1. Patient has plexiform neurofibromas that are inoperable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GROWTH HORMONE, NON-PREFERRED (S)

Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Omnitrope
- Saizen
- Saizenprep Reconstitutionkit
- Zomacton

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A

Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	All uses (initial):Trial and failure or intolerance to Genotropin. AGHD(initial):dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin at or below 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin at or below 2.8 ng/mL 30,45,60,90 mins after admin].
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GROWTH HORMONE, PREFERRED (S)

Products Affected

- Genotropin
- Genotropin Miniquick
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)]. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A

Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	AGHD(initial):dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin at or below 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin at or below 2.8 ng/mL 30,45,60,90 mins after admin].
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HAEGARDA (S)

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 6 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HALAVEN (S)

Products Affected

- Eribulin Mesylate
- Halaven

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HARLIKU (S)

Products Affected

- Harliku

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of alkaptonuria (AKU). Used for the reduction of urine homogentisic acid (HGA). Disease is confirmed by one of the following: a) Presence of a mutation in the homogentisate 1,2-dioxygenase (HGD) gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), or b) Presence of elevated homogentisic acid (HGA) levels in urine greater than 0.4 g/24h.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a rheumatologist, geneticist, or specialist experienced in the treatment of inborn errors of metabolism.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HARVONI (S)

Products Affected

- Harvoni
- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All (including patients with genotype 5 or 6 infection AND decompensated cirrhosis): A) Diagnosis of chronic hepatitis C, B) Patient is not receiving ledipasvir/sofosbuvir in combination with another HCV direct acting antiviral agent [eg, Sovaldi (sofosbuvir)]. ONE of the following: Trial and failure, intolerance, or contraindication (eg, safety concerns, not indicated for patient's age/weight) to a) Mavyret (except patients with decompensated cirrhosis, and b) sofosbuvir/velpatasvir, OR for continuation of prior ledipasvir/sofosbuvir therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HEPCLUDEX (S)

Products Affected

- Hepcludex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic hepatitis delta virus (HDV) infection. Patient had detectable HDV RNA before initiating therapy. Patient is without decompensated liver disease (eg, Child-Pugh Class B or C).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HERCEPTIN (S)

Products Affected

- Herceptin INJ 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HERCEPTIN HYLECTA (S)

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HERCESSI (S)

Products Affected

- Hercessi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HERNEXEOS (S)

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-squamous non-small cell lung cancer (NSCLC). Disease is one of the following: a) unresectable, b) metastatic. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HERZUMA (S)

Products Affected

- Herzuma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HETLIOZ (S)

Products Affected

- Hetlioz
- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-24-Hour Sleep-Wake Disorder (Non-24) (initial): Both of the following: 1) Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome), AND 2) patient is totally blind (has no light perception). Smith-Magenis Syndrome (SMS) (initial): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
Age Restrictions	SMS (initial): 16 years of age or older
Prescriber Restrictions	Non-24 (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist. SMS (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist.
Coverage Duration	Non-24, SMS (initial): 6 mo. (reauth): 12 mo
Other Criteria	Non-24, SMS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HETLIOZ LQ (S)

Products Affected

- Hetlioz Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Smith-Magenis Syndrome (SMS) (initial): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
Age Restrictions	SMS (initial): Patient is 3 through 15 years of age
Prescriber Restrictions	SMS (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist.
Coverage Duration	SMS (initial): 6 mo. (reauth): 12 mo
Other Criteria	SMS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HRM - PAIN MEDICATIONS

Products Affected

- Demerol INJ 100MG/ML, 25MG/ML, 50MG/ML, 75MG/ML
- Meperidine Hcl INJ 100MG/ML, 25MG/ML, 50MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HUMIRA (S)

Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A

Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS, PJIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
Coverage Duration	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

Other Criteria	Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Hidradenitis Suppurativa (HS) (Initial): Diagnosis of moderate to severe HS (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the abscess and inflammatory nodule count from baseline, reduced formation of new sinus tracts and scarring, improvement in symptoms (eg, pain, suppuration) from baseline. Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HYFTOR (S)

Products Affected

- Hyftor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of facial angiofibroma associated with tuberous sclerosis complex.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist, neurologist, or geneticist.
Coverage Duration	Initial: 4 months, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYRNUO (S)

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-squamous non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IBRANCE (S)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBSRELA (S)

Products Affected

- Ibsrela

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Irritable Bowel Syndrome with Constipation (IBS-C) (initial): Diagnosis of IBS-C. Trial and failure, contraindication, or intolerance to ONE of the following: a) generic lubiprostone OR b) Linzess.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	IBS-C (initial, reauth): 12 months.
Other Criteria	IBS-C (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IBTROZI (S)

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: 1) Locally advanced or 2) Metastatic. Presence of ROS1 rearrangement-positive tumor as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ICLUSIG (S)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL). One of the following: a) Used in combination with chemotherapy up to 20 cycles OR b) Used as monotherapy in patients where one of the following applies: i) No other kinase inhibitors are indicated OR ii) Disease is T315I-positive Ph+ ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IDHIFA (S)

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Patient has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH2 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IGALMI (S)

Products Affected

- Igalmi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: Schizophrenia or Bipolar I or II disorder. For the treatment of acute agitation. Trial and failure, contraindication or intolerance to at least two products used in acute agitation (e.g., olanzapine, ziprasidone). Patient is currently being managed with maintenance medication for their underlying disorder (e.g., aripiprazole, olanzapine, quetiapine, lithium, valproic acid).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ILARIS (S)

Products Affected

- Ilaris INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Periodic Fever Syndromes (PFS) (Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever (FMF)). (Initial) Diagnosis of one of the autoinflammatory Periodic Fever Syndromes: CAPS (including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS)), TRAPS, HIDS/MKD, or FMF, AND The medication will not be used in combination with another biologic agent. Systemic juvenile idiopathic arthritis (sJIA) (Initial): Diagnosis of active sJIA. Still's Disease (Initial): Diagnosis of Still's Disease, including Adult-Onset Still's Disease (AOSD). SJIA, Still's Disease (initial): Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic corticosteroid (e.g., prednisone). Gout flares: Diagnosis of gout flares. Trial and failure, contraindication, or intolerance to TWO of the following: a) NSAIDs (e.g., ibuprofen, naproxen), b) colchicine, or c) corticosteroids (e.g., prednisone). Patient has not received Ilaris in the last 12 weeks.
Age Restrictions	N/A
Prescriber Restrictions	PFS (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, or neurologist. SJIA, Still's Disease (initial): Prescribed by or in consultation with a rheumatologist. Gout flares: Prescribed by or in consultation with a rheumatologist or nephrologist.
Coverage Duration	PFS, SJIA, Still's disease (initial): 6 months, (reauth): 12 months. Gout flares: 12 weeks.

Other Criteria	PFS, Still's Disease (Reauth): Patient demonstrates positive clinical response to therapy. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ILUMYA (S)

Products Affected

- Ilumya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque Psoriasis (initial): Diagnosis of moderate-to-severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plaque Psoriasis (initial): 6 months. Plaque Psoriasis (reauth): 12 months.
Other Criteria	Plaque Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMBRUVICA (S)

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD AND trial and failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate).
Age Restrictions	(cGVHD): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMDELLTRA (S)

Products Affected

- Imdelltra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of extensive stage small cell lung caner (ES-SCLC). Disease has progressed on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMFINZI (S)

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMJUDO (S)

Products Affected

- Imjudo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMKELDI (S)

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome/BCR ABL-positive (Ph+/BCR ABL+) CML. Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Ph+/BCR ABL+ ALL. Myelodysplastic Disease (MDS)/Myeloproliferative Disease (MPD): Diagnosis of MDS/MPD. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: a) HES or b) CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST. All indications: Patient is unable to swallow generic imatinib tablet due to one of the following: a) Age, b) Physical impairment (e.g., difficulties with motor or oral coordination), c) Dysphagia, or d) Patient is using a feeding tube or nasal gastric tube.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMVEXXY (S)

Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Dyspareunia (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INBRIJA (S)

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing intermittent OFF episodes. Patient is currently being treated with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B inhibitor (e.g., rasagiline, selegiline), dopamine agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (initial, reauth): 12 months
Other Criteria	PD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INCRELEX (S)

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	(Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INFLECTRA (S)

Products Affected

- Inflectra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (eg, prednisone), methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Prescriber Restrictions	RA, AS: Prescribed by or in consultation with a rheumatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist. CD, FCD, UC: Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months.
Other Criteria	Ankylosing spondylitis (AS) (initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (initial): Dx of sarcoidosis. TF/C/I to one of the following: corticosteroid (eg, prednisone) OR immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine). Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INGREZZA (S)

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease (initial): Diagnosis of chorea in patients with Huntington's disease.
Age Restrictions	N/A
Prescriber Restrictions	Tardive Dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	initial, reauth: 12 months
Other Criteria	All Uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INJECTABLE TESTOSTERONE, NON-PREFERRED (S)

Products Affected

- Aveed
- Xyosted

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (Initial), GD: Trial or intolerance to generic testosterone enanthate. Trial and failure or intolerance to generic testosterone cypionate. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLURIYO (S)

Products Affected

- Inluriyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor-1 (ESR1) mutation(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLYTA (S)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: (1) used as first-line treatment in combination with avelumab or pembrolizumab or (2) used after failure of one prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INQOVI (S)

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic syndrome (MDS) or chronic myelomonocytic leukemia (CMML): Diagnosis of one of the following: i) MDS or ii) CMML. Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS). Acute Myeloid Leukemia (AML): Diagnosis of newly-diagnosed AML. Used in combination with venetoclax. One of the following: a) Patient is 75 years of age or older or b) Patient has comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months
Other Criteria	All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INREBIC (S)

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INTRAROSA (S)

Products Affected

- Intrarosa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance to one of the following: Estrace (estradiol) vaginal cream or Premarin (conjugated estrogens) vaginal cream.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Dyspareunia (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INZIRQO (S)

Products Affected

- Inzirqo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Used for the treatment of hypertension or B) Both of the following: 1) Used for the treatment of edema and 2) Diagnosis of one of the following: a) congestive heart failure, b) hepatic cirrhosis, or c) renal disease (e.g., nephrotic syndrome). One of the following: A) Intolerance to generic hydrochlorothiazide capsules or tablets or B) Patient is unable to swallow a solid oral dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IQIRVO (S)

Products Affected

- Iqirvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary biliary cholangitis (PBC) (aka primary biliary cirrhosis). One of the following: A) Both of the following: 1) Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND 2) Used in combination with UDCA, OR B) History of contraindication or intolerance to UDCA. Requested drug will not be used in combination with Livdelzi (seladelpar).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Livdelzi (seladelpar).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IRESSA (S)

Products Affected

- Gefitinib
- Iressa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISEMBYLD (S)

Products Affected

- Isembyld

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISTODAX (S)

Products Affected

- Istodax
- Romidepsin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISTURISA (S)

Products Affected

- Isturisa TABS 1MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's Syndrome (initial): Diagnosis of Cushing's syndrome. Used for treatment of endogenous hypercortisolemia. One of the following: a) Patient is not a candidate for surgery (e.g., adrenalectomy, transsphenoidal surgery), OR b) Surgery has not been curative for the patient.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's Syndrome (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's Syndrome (initial, reauth): 12 months
Other Criteria	Cushing's Syndrome (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ITOVEBI (S)

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: a) Locally advanced, or b) Metastatic. Disease is all of the following (as detected by a U.S. Food and Drug Administration [FDA]-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments [CLIA]): a) PIK3CA-mutated, b) Hormone receptor (HR)-positive, c) Human epidermal growth-factor receptor 2 (HER2)-negative. Used following recurrence on or after completing adjuvant endocrine therapy (e.g. Zoladex [goserelin], Arimidex [anastrozole], Nolvadex [tamoxifen]). Used in combination with both of the following: a) Ibrance (Palbociclib), and b) Fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITRACONAZOLE CAPSULE (S)

Products Affected

- Itraconazole CAPS
- Sporanox CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infection (SFI): Diagnosis of a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis). Fingernail Onychomycosis: Diagnosis of fingernail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine. Toenail Onychomycosis: Diagnosis of toenail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SFI:6mo.Fingernail Onychomycosis:5wks.Toenail Onychomycosis:3mo.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITRACONAZOLE SOLUTION (S)

Products Affected

- Itraconazole SOLN
- Sporanox SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Candidiasis: Diagnosis of esophageal or oropharyngeal candidiasis. One of the following: i) Trial and failure, contraindication, or intolerance to fluconazole OR ii) Susceptibility results demonstrate resistance to fluconazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Candidiasis: 1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IVERMECTIN (S)

Products Affected

- Ivermectin TABS
- Stromectol TABS 3MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite Strongyloides stercoralis. Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IVIG (S)

Products Affected

- Alyglo
- Asceniv
- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/100ML, 10GM/200ML, 2.5GM/50ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gammagard Liquid
- Gammagard Liquid Erc
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Panzyga
- Privigen
- Qivigy
- Yimmugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A

Required Medical Information	Initial: Immune globulin (Ig) will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. For IVIG - Ig is being used intravenously (IV) AND One of the following diagnoses: [A] Primary Immunodeficiency 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). [B] Secondary Acquired Antibody Deficiency 1) B-cell chronic lymphocytic leukemia with an Ig level less than 500 mg/dL OR history of recurrent bacterial infections. 2) HIV infection with an Ig level less than 400 mg/dL OR Patient has active bleeding or a platelet count less than 10 x 109/L. 3) Multiple myeloma in plateau phase and patient has hypogammaglobulinemia. [C] Hematological Autoimmune Disorders 1) Acquired (pure) red cell aplasia (PRCA) that is immunologic and patient had a trial and failure, contraindication, or intolerance (TF/C/I) to a corticosteroid and an immunosuppressant (i.e., cyclophosphamide, cyclosporine) OR patient has viral PRCA caused by parvovirus B19. 2) Fetal alloimmune thrombocytopenia. 3) Hemolytic disease of the newborn and the patient has established hyperbilirubinemia. 4) Idiopathic thrombocytopenic purpura and patient had a TF/C/I to a corticosteroid OR a platelet count less than 30,000 cells/mm3. Continued in Other Criteria Section.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist).
Coverage Duration	All diagnoses: 12 months

Other Criteria	[D] Neuromuscular Autoimmune Disorders 1) Chronic inflammatory demyelinating polyneuropathy. 2) Guillain-Barré syndrome. 3) Inflammatory myopathies (dermatomyositis or polymyositis) AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus). 4) Lambert-Eaton myasthenic syndrome AND Patient had a TF/C/I to a corticosteroid. 5) Multifocal motor neuropathy. 6) Myasthenia gravis with severe exacerbations or myasthenic crises. 7) Stiff person syndrome AND Patient had a TF/C/I to at least one standard therapy (i.e., baclofen, corticosteroid). [E] Other Disorders 1) Autoimmune blistering disease AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., dapsone, methotrexate, azathioprine, or mycophenolate mofetil). 2) Kawasaki syndrome. 3) Solid organ transplant and IVIG is being used for CMV prophylaxis, or patient is a kidney transplant recipient and has donor specific antibodies, or patient has steroid-resistant rejection and had a TF/C/I to standard therapies. For SCIG (Gamunex-C, Gammagard Liquid, Gammaked only)- Immune globulin is being used subcutaneously AND One of the following PI diagnoses: 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). All products: Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. For non-oncology renewal, the patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IWILFIN (S)

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of high-risk neuroblastoma (HRNB). Patient has shown at least a partial response to prior multiagent, multimodality therapy. Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IZERVAY (S)

Products Affected

- Izervay

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration. Disease is confirmed by one of the following: a) fundus photography (e.g. fundus autofluorescence [FAF]), b) optical coherence tomography (OCT), or c) fluorescein angiography.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JAKAFI (S)

Products Affected

- Jakafi
- Jakafi Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND trial and failure, contraindication, or intolerance to hydroxyurea. Acute graft versus host disease (aGVHD): Diagnosis of aGVHD. Disease is steroid-refractory. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD. Trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JASCAYD (S)

Products Affected

- Jascayd

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF) (Initial): Diagnosis of IPF as documented by both of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. One of the following: a) both of the following: i) Jascayd will be used as monotherapy, AND ii) trial and inadequate response, contraindication, or intolerance to one of the following: generic pirfenidone OR generic nintedanib, b) Jascayd will be used in combination with one of the following: Brand Ofev, generic nintedanib, OR generic pirfenidone, OR c) for continuation of prior therapy. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype, Progressive Pulmonary Fibrosis (PPF) (Initial): Diagnosis of chronic fibrosing interstitial lung disease or progressive pulmonary fibrosis (PPF). Patient has a high-resolution computed tomography (HRCT) showing fibrotic features. Disease has a progressive phenotype as observed by one of the following: a) Decline of forced vital capacity (FVC), b) Worsening of respiratory symptoms, or c) Increased extent of fibrosis seen on imaging.
Age Restrictions	N/A
Prescriber Restrictions	IPF (Initial): Prescribed by or in consultation with a pulmonologist. Chronic Fibrosing ILDs with a Progressive Phenotype, PPF (Initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	All uses (Initial, Reauth): 12 months.

Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JATENZO (S)

Products Affected

- Jatenzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (init): Trial and failure or intolerance to generic testosterone gel. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAVADIN (S)

Products Affected

- Javadin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hypertension. One of the following: 1) Intolerance to generic clonidine tablets or 2) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAVYGTOR (S)

Products Affected

- Javygtor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response. Trial or intolerance to generic sapropterin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months. PKU (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAYPIRCA (S)

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior therapies for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Disease is one of the following: a) Relapsed, or b) Refractory. Patient has previously been treated with a covalent BTK inhibitor [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAYTHARI (S)

Products Affected

- Jaythari TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of Duchenne muscular dystrophy (DMD). Patient has received genetic testing for a mutation of the dystrophin gene. Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following: A) Documentation of a confirmed mutation of the dystrophin gene or B) Muscle biopsy confirmed an absence of dystrophin protein. Patient has had a trial and failure or intolerance to prednisone or prednisolone.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JEMPERLI (S)

Products Affected

- Jemperli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JEVTANA (S)

Products Affected

- Jevtana

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JIDEYTRO (S)

Products Affected

- Jideytro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer: Diagnosis of non-small cell lung cancer. Disease is i) locally advanced or ii) metastatic. Presence of ROS1 rearrangement positive tumor(s) as detected by a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior treatment with a ROS1 kinase inhibitor (e.g., Augtyro, Xalkori, Rozlytrek).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JOENJA (S)

Products Affected

- Joenja

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS). Molecular genetic testing confirms mutations in the PIK3CD or PIK3R1 gene. Patient weighs greater than or equal to 45kg. Both of the following: a) Presence of nodal and/or extranodal proliferation (e.g., lymphadenopathy, splenomegaly, hepatomegaly) and b) Presence of other clinical findings and manifestations consistent with APDS (e.g., recurrent sino-pulmonary infections, bronchiectasis, enteropathy). Trial and failure, contraindication, or intolerance to at least one standard of care treatment for APDS (e.g., Immunoglobulin replacement therapy).
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: geneticist, hematologist, or immunologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JUVMO (S)

Products Affected

- Juvmo
- Juvmo Titration Pack

PA Criteria	Criteria Details
Indications	N/A
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A
Prerequisite Therapy Required	

JUXTAPID (S)

Products Affected

- Juxtapid CAPS 10MG, 20MG, 2MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) untreated LDL-C greater than 400 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. One of the following: a) patient is receiving other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. One of the following: a) Patient is less than 10 years of age, or b) both of the following: 1) patient is 10 years of age or older AND 2) trial and failure, contraindication, or intolerance to Repatha therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, or hepatologist.
Coverage Duration	HoFH (initial): 6 months. (reauth): 12 months
Other Criteria	HoFH (reauthorization): One of the following: a) patient continues to receive other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Submission of medical records (eg, chart notes, laboratory values) documenting LDL-C reduction from baseline while on therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JYLAMVO (S)

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neoplastic diseases: Diagnosis of one of the following: A) acute lymphoblastic leukemia (ALL), B) mycosis fungoides (cutaneous T-cell lymphoma), or C) relapsed or refractory non-hodgkin lymphomas. Rheumatoid arthritis (RA): Diagnosis of RA. Psoriasis: Diagnosis of severe psoriasis. Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist. Psoriasis: Prescribed by or in consultation with a dermatologist. pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Neoplastic diseases, RA, Psoriasis, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JYNARQUE (S)

Products Affected

- Jynarque
- Tolvaptan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Autosomal dominant polycystic kidney disease (ADPKD) (initial): Diagnosis of rapidly progressing ADPKD. One of the following: 1) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months. Patient does not have a history of significant liver impairment or injury, not including uncomplicated polycystic liver disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	ADPKD (reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient does not have signs or symptoms consistent with hepatic injury or 2) Patient has uncomplicated polycystic liver disease. One of the following: 1) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received tolvaptan (brand or generic Jynarque) for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KADCYLA (S)

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KALBITOR (S)

Products Affected

- Kalbitor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 12 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KALYDECO (S)

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of cystic fibrosis. Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (initial): Patient is 1 month of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient demonstrates positive clinical response (i.e. improvement in lung function [percent predicted forced expiratory volume in one second (PPFEV1)], decreased number of pulmonary exacerbations) while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KANJINTI (S)

Products Affected

- Kanjinti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KANUMA (S)

Products Affected

- Kanuma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of lysosomal acid lipase deficiency (e.g., LAL-D, Wolman Disease, Cholesteryl ester storage disease). Diagnosis was confirmed by one of the following: a) enzymatic blood test (e.g., dried blood spot test) demonstrating a deficiency of LAL enzyme activity, OR b) genetic testing for mutations in the Lipase A, Lysosomal Acid Type (LIPA) gene.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a specialist experienced in the treatment of inborn errors of metabolism, gastroenterologist, or lipidologist
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KERENDIA (S)

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic kidney disease (CKD) associated with type 2 diabetes (T2D) (Initial): Diagnosis of CKD associated with T2D. Patient has a urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g. Patient has an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2. Patient has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. One of the following: 1) Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following: a) generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. Heart failure (HF) with Left Ventricular Ejection Fraction (LVEF) greater than or equal to 40% (Initial): Diagnosis of HF. Patient has LVEF greater than or equal to 40%. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. Patient has an eGFR greater than or equal to 25 mL/min/1.73 m2. Patient has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. Both of the following: 1) Patient is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment, AND 2) Patient is not receiving drug in combination with spironolactone or eplerenone. One of the following: 1) Patient is receiving drug in combination with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	HF with LVEF greater than or equal to 40% (Initial): Prescribed by or in consultation with a cardiologist.

Coverage Duration	Initial, Reauth: 12 months
Other Criteria	CKD associated with T2D (Reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB, OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs. HF with LVEF greater than or equal to 40% (Reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on an SGLT2 inhibitor, OR 2) Patient has a contraindication or intolerance to an SGLT2 inhibitor.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KERYDIN (S)

Products Affected

- Kerydin
- Tavaborole

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Onychomycosis: Patient has a diagnosis of onychomycosis of the toenails. Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, b) culture, or c) histology. Trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KESIMPTA (S)

Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (Initial): Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to one disease-modifying therapy for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya fingolimod)], OR 2) For continuation of prior therapy. Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ocrelizumab [Ocrevus]).
Age Restrictions	N/A
Prescriber Restrictions	MS (Initial, Reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (Initial, Reauth): 12 months
Other Criteria	MS (Reauth): Patient demonstrates positive clinical response to therapy. Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ocrelizumab [Ocrevus]).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KEVEYIS (S)

Products Affected

- Dichlorphenamide
- Keveyis
- Ormalvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Periodic paralysis (Initial): Diagnosis of one of the following: Primary hyperkalemic periodic paralysis, Primary hypokalemic periodic paralysis, Paramyotonia Congenita with periodic paralysis, or Andersen-Tawil syndrome. Provider attests that other known causes of potassium fluctuations have been excluded (e.g., thyrotoxic periodic paralysis, drugs that cause potassium abnormalities, etc.).
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	All uses (Initial): 3 months. (Reauth): 12 months
Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KEVZARA (S)

Products Affected

- Kevzara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Diagnosis of active PJIA. Patient weighs at least 63 kg. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel, one formulary adalimumab product, Orencia, Rinvoq/LQ, or Xeljanz, OR b) for continuation of prior therapy. Polymyalgia Rheumatica (PMR) (initial): Diagnosis of PMR. One of the following: a) Patient has had an inadequate response to corticosteroids (e.g., prednisone), OR b) Patient cannot tolerate tapering of corticosteroids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, PMR (initial): Prescribed by or in consultation with a rheumatologist
Coverage Duration	RA, PJIA, PMR (initial): 6 months, (reauth): 12 months
Other Criteria	RA, PJIA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PMR (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: a) improvement in symptoms (eg, pain, stiffness) or lab values (eg, C-reactive protein) from baseline, or b) reduced need for corticosteroids (eg, prednisone).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KEYTRUDA (S)

Products Affected

- Keytruda INJ 100MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KHINDIVI (S)

Products Affected

- Khindivi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of adrenocortical insufficiency. One of the following: 1) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), or 2) Dosage requirements cannot be met with a solid dosage form.
Age Restrictions	Initial: Patient is between 5 and 18 years of age.
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KIMMTRAK (S)

Products Affected

- Kimmtrak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KINERET (S)

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID AND dx of NOMID has been confirmed by one of the following: 1) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3) gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation OR 2) Both of the following: a) two of the following clinical symptoms: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia), chronic aseptic meningitis, or skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing) AND b) elevated acute phase reactants (eg, erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA]). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA.
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.
Coverage Duration	RA, NOMID (initial): 6 months, (reauth): 12 months. DIRA: 12 months.

Other Criteria	RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KISQALI (S)

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KISQALI-FEMARA PACK (S)

Products Affected

- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOMZIFTI (S)

Products Affected

- Komzifti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible nucleophosmin 1 (NPM1) mutation as detected by a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORLYM (S)

Products Affected

- Korlym
- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's syndrome (Initial): Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	Reauth: Patient demonstrates one of the following: patient has improved glucose tolerance while on therapy or patient has stable glucose tolerance while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORSUVA (S)

Products Affected

- Korsuva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic kidney disease (CKD) (init): Diagnosis of CKD. Patient is currently undergoing hemodialysis (HD). Patient is experiencing moderate to severe pruritus associated with CKD (CKD-aP). Exclusion of other causes of pruritus (e.g., eczema, infections, drug-induced skin dryness). Trial and failure of at least two standard of care treatments for CKD-aP (e.g., topical corticosteroids [e.g., hydrocortisone, triamcinolone], oral antihistamines [e.g., diphenhydramine, hydroxyzine], gabapentin, pregabalin).
Age Restrictions	N/A
Prescriber Restrictions	CKD (init): Prescribed by or in consultation with a nephrologist or dermatologist.
Coverage Duration	CKD (init): 3 months. CKD (reauth): 12 months.
Other Criteria	Subject to ESRD review. CKD (reauth): Patient is currently undergoing HD. Patient demonstrates positive clinical response to therapy (e.g., improved worst itching intensity numerical rating score from baseline).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KOSELUGO (S)

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KRAZATI (S)

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: locally advanced or metastatic. Disease is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Colorectal Cancer (CRC): Diagnosis of CRC. Disease is one of the following: locally advanced or metastatic. Tumor is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA) -approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Erbitux (cetuximab). Patient has received prior treatment with ALL of the following: a) fluoropyrimidine-based chemotherapy, b) oxaliplatin-based chemotherapy, and c) irinotecan-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KRYSTEXXA (S)

Products Affected

- Krystexxa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gout (initial): Diagnosis of gout. Trial, failure, contraindication or intolerance to two of the following conventional therapies: allopurinol, febuxostat, or probenecid. One of the following: history of at least two gout flares in the previous 12 months or at least 1 gouty tophus.
Age Restrictions	N/A
Prescriber Restrictions	Gout (initial): Prescribed by or in consultation with a rheumatologist or nephrologist.
Coverage Duration	Gout (initial, reauth): 12 months
Other Criteria	Gout (reauth): Serum urate level has decreased since initiating therapy. Clinical improvement in the signs and symptoms of gout (e.g., decrease in tophi size or frequency of gouty flares per year from baseline or improvement in chronic arthropathy or quality of life).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KUVAN (S)

Products Affected

- Sapropterin Dihydrochloride
- Zelvysia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KUVAN BRAND (S)

Products Affected

- Kuvan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response. Trial or intolerance to generic sapropterin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (Init): 2 months. PKU (Reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KYGEVVI (S)

Products Affected

- Kygevvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of thymidine kinase 2 deficiency (TK2d). Diagnosis confirmed by the presence of a mutation in the TK2 gene. Patient experienced symptom onset on or before 12 years of age.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a clinical specialist knowledgeable in the treatment of TK2d (e.g., geneticist, neurologist).
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Provider attests the patient would benefit from continued therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KYPROLIS (S)

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KYZATREX (S)

Products Affected

- Kyzatrex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (init): Trial and failure or intolerance to generic testosterone gel. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LAMZEDE (S)

Products Affected

- Lamzede

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of alpha-mannosidosis. Disease is confirmed by one of the following: a) Deficiency in alpha-mannosidase enzyme activity as measured in fibroblasts or leukocytes, OR b) Molecular genetic testing confirms mutations in the MAN2B1 gene. Treatment is only for non-central nervous system disease manifestations (e.g., large head, prominent forehead, protruding jaw, skeletal abnormalities).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient does not show evidence of progressive disease while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LANREOTIDE (S)

Products Affected

- Lanreotide Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly: Diagnosis of acromegaly. One of the following: A) Inadequate response to one of the following: surgery or radiotherapy, OR B) Not a candidate for one of the following: surgery or radiotherapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (120mg/0.5mL strength only): Diagnosis of GEP-NETs. Disease is one of the following: (a) unresectable, locally advanced or (b) metastatic. Carcinoid syndrome (120mg/0.5mL strength only): Diagnosis of carcinoid syndrome. Used to reduce the frequency of short-acting somatostatin analog rescue therapy.
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist. Carcinoid syndrome (initial): Prescribed by or in consultation with an endocrinologist or oncologist.
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LASIX ONYU (S)

Products Affected

- Lasix Onyu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic heart failure (CHF). Drug will be used for the treatment of edema. Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LAZCLUZE (S)

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Used as first line treatment of NSCLC. Used in combination with Rybrevant (amivantamab). Presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEMTRADA (S)

Products Affected

- Lemtrada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Patient has not been previously treated with alemtuzumab, and trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod)] or 2) Patient has previously received treatment with alemtuzumab, and at least 12 months have or will have elapsed since the most recent treatment course with alemtuzumab. Not used in combination with another disease-modifying therapy for MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist
Coverage Duration	MS: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LENVIMA (S)

Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg 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 Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Renal Cell Carcinoma (RCC): Diagnosis of RCC. One of the following: 1) Both of the following: a) Used as first-line treatment and b) Used in combination with Keytruda (pembrolizumab), or 2) Both of the following: a) Treatment follows one prior anti-angiogenic therapy and b) Used in combination with everolimus. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Endometrial Carcinoma (EC): Diagnosis of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H), or mismatch repair deficient (dMMR) [i.e. disease is mismatch repair proficient (pMMR)], as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has disease progression following systemic therapy. Used in combination with Keytruda (pembrolizumab) therapy. Patient is not a candidate for curative surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LEQEMBI IQLIK (S)

Products Affected

- Leqembi Iqlik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Alzheimer's disease. Disease is confirmed by the presence of beta amyloid pathology (e.g., PET scan, cerebrospinal fluid (CSF) biomarker [e.g., Abeta42 level, Abeta42:Abeta40 ratio, Tau, p-Tau]). For Leqembi IQLIK 360mg/1.8mL subcutaneous solution: Will be used as a maintenance dose following completion of 18 months with either Leqembi intravenous or Leqembi IQLIK 500mg. Initial, Reauth: Not used in combination with other Abeta monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by a neurologist, geriatrician, or geriatric psychiatrist.
Coverage Duration	Initial, Reauth: 6 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LEQVIO (S)

Products Affected

- Leqvio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous Familial Hypercholesterolemia (HeFH)/Atherosclerotic Cardiovascular Disease (ASCVD)/Primary Hyperlipidemia or Hypercholesterolemia (Initial): One of the following: A) HeFH, B) ASCVD (e.g., history of acute coronary syndromes, myocardial infarction, stable/unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral artery disease), OR C) primary hyperlipidemia or hypercholesterolemia. One of the following: A) Pt has been receiving highest tolerable dose of statin, B) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable sx or clinically significant biomarker changes of liver or muscle function (e.g., creatine kinase), OR C) Pt has an FDA labeled contraindication to all statins. Pt has been receiving ezetimibe as adjunct to max tolerated statin or hx of contraindication/intolerance to ezetimibe. One of the following: A) both of the following: i) Pt has been receiving PCSK9 therapy (e.g., Repatha, Praluent) as adjunct to max tolerated lipid lowering tx (e.g., statins, ezetimibe) AND ii) Despite adherence to PCSK9, pt has been unable to achieve LDL-C goal as evidenced by 1 in the last 120 days: a) LDL-C greater than or equal to 55mg/dL with ASCVD, b) LDL-C greater than or equal to 70mg/dL without ASCVD but at high risk (e.g., with ASCVD risk factors [age greater than or equal to 65, current smoker, diabetes], subclinical atherosclerosis), or c) LDL-C greater than or equal to 100mg/dL without ASCVD and not at high risk, OR B) Pt is unable to maintain adherence to PCSK9 due to one of the following: i) Manual dexterity problems (e.g., tremors, arthritis) OR ii) Visual impairment (e.g., best-corrected visual acuity of 20/200 or worse), OR C) Pt had hypersensitivity reaction, defined as angioedema, vasculitis, urticaria, to a PCSK9 inhibitor. Med will not be used in combo with a PCSK9 inhibitor.
Age Restrictions	HoFH (initial): Patient is 12 years of age or older.

Prescriber Restrictions	N/A
Coverage Duration	All Indications (Initial, Reauth): 12 months.
Other Criteria	HeFH/ASCVD/Primary Hyperlipidemia or Hypercholesterolemia (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by LDL-C reduction from baseline. One of the following: A) Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose, OR B) Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe). Medication will not be used in combination with PCSK9 inhibitor therapy. Homozygous Familial Hypercholesterolemia (HoFH) (Initial): Diagnosis of HoFH as confirmed by one of the following: A) Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH), OR B) Both of the following: i) Untreated LDL-C greater than 400 mg/dL AND ii) Either xanthoma before 20 years of age OR evidence of HeFH in both parents. One of the following: A) Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe), OR B) Patient has a documented inability to take other lipid-lowering therapy (e.g., statin, ezetimibe). HoFH (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by LDL-C reduction from baseline. One of the following: A) Patient continues to receive other lipid-lowering therapy (e.g., statin, ezetimibe), OR B) Patient has a documented inability to take other lipid-lowering therapy (e.g., statin, ezetimibe).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LEROCHOL (S)

Products Affected

- Lerochol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: A) Heterozygous familial hypercholesterolemia (HeFH), B) Atherosclerotic cardiovascular disease (ASCVD) (e.g., history of acute coronary syndromes [ACS], myocardial infarction [MI], stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack [TIA], or peripheral artery disease [PAD]), OR C) Primary hyperlipidemia (HLD) or hypercholesterolemia. One of the following: A) Patient has been receiving highest tolerable dose of statin therapy, B) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, OR C) Patient has an FDA labeled contraindication to all statins. One of the following: A) Trial, contraindication, or intolerance to Repatha OR Praluent OR B) For continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline. One of the following: A) Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) OR B) Patient has a documented inability to take other lipid-lowering therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LETAIRIS (S)

Products Affected

- Ambrisentan
- Letairis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEUKINE (S)

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bone marrow/stem cell transplant (BMSCT): One of the following: 1) patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, OR 2) used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR 3) patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy. Acute myeloid leukemia (AML): Diagnosis of AML. Patient has completed induction or consolidation chemotherapy. Age greater than or equal to 55 years. Febrile Neutropenia (FN) Prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with a greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5)Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of High-Risk FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. HIV-related neutropenia (HIVN): Patient is infected with HIV, and absolute neutrophil count (ANC) less than or equal to 1000 (cells/mm^3).

Age Restrictions	BMSCT: Patient is 2 years of age or older.
Prescriber Restrictions	HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist. All other uses:Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	BMSCT, AML, FN (prophylaxis, treatment):3mo or duration of tx. HIVN:6mo. ARS:1 mo.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIBTAYO (S)

Products Affected

- Libtayo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LICART (S)

Products Affected

- Licart

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).
Required Medical Information	Pain: Diagnosis of acute, localized pain due to minor strains, sprains and contusions. Patient meets one of the following: 1) Treatment failure with at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen). OR 2) History of peptic ulcer disease/gastrointestinal bleed. OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIDOCAINE TOPICAL (S)

Products Affected

- Lidocaine OINT 5%
- Lidocaine Hcl PRSY
- Lidocaine Hcl Jelly PRSY
- Lidocaine Hydrochloride SOLN
- Lidocaine Hydrochloride Jelly
- Lidocaine/prilocaine CREA
- Numyra
- Pliaglis CREA
- Premium Lidocaine
- Topicaine GEL 2%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDODERM (S)

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDODERM BRAND (S)

Products Affected

- Lidocan
- Lidoderm
- Tridacaine
- Tridacaine II
- Tridacaine III

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIFYORLI (S)

Products Affected

- Lifyorli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Disease is platinum resistant. Used in combination with nab-paclitaxel. Patient has received one prior bevacizumab-containing systemic treatment regimen. Patient has not received more than three prior systemic treatment regimens (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIKMEZ (S)

Products Affected

- Likmez

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: A) Trichomoniasis, B) Amebiasis, or C) Anaerobic bacterial infection (e.g., intra-abdominal infections, skin and skin structure infections, gynecologic infection). Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIPFENDRA (S)

Products Affected

- Lipfendra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: A) Heterozygous familial hypercholesterolemia (HeFH), B) Atherosclerotic cardiovascular disease (ASCVD) (e.g., history of acute coronary syndromes [ACS], myocardial infarction [MI], stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack [TIA], or peripheral artery disease [PAD]), OR C) Primary hyperlipidemia or hypercholesterolemia. One of the following: A) Patient has been receiving highest tolerable dose of statin therapy, B) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, OR C) Patient has an FDA labeled contraindication to all statins. Trial, contraindication, or intolerance to Repatha OR Praluent. Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline. One of the following: A) Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) OR B) Patient has a documented inability to take other lipid-lowering therapy. Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LITFULO (S)

Products Affected

- Litfulo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of alopecia areata. Patient has at least 50% scalp hair loss. Other causes of hair loss have been ruled out (eg, other types of alopecia, scalp disease, active systemic disease). Initial, Reauth: Not used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine or other potent immunosuppressants.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIVDELZI (S)

Products Affected

- Livdelzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary biliary cholangitis (PBC) (also known as primary biliary cirrhosis). One of the following: A) Both of the following: 1) Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND 2) Used in combination with UDCA, OR B) History of contraindication or intolerance to UDCA. Requested drug will not be used in combination with Iqirvo (elafibranor).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Iqirvo (elafibranor).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIVMARLI (S)

Products Affected

- Livmarli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Alagille syndrome (ALGS) (initial): Both of the following: a) Diagnosis of ALGS, and b) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene. Progressive Familial Intrahepatic Cholestasis (PFIC) (initial): Both of the following: a) Diagnosis of PFIC, and b) Molecular genetic testing confirms mutations in the ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, or MYO5B gene.
Age Restrictions	ALGS (initial): Patient is 3 months of age or older. PFIC (initial): Patient is 12 months of age or older.
Prescriber Restrictions	All indications (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	ALGS (initial, reauth): 12 months. PFIC (initial): 6 months, (reauth): 12 months.
Other Criteria	All indications (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LOARGYS (S)

Products Affected

- Loargys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hyperargininemia. Disease is confirmed by the presence of arginase 1 deficiency (ARG1-D) as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a specialist with expertise in the treatment of metabolic disorders.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LODOCO (S)

Products Affected

- Lodoco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of atherosclerotic disease. Used for the secondary prevention of cardiovascular (CV) disease events (e.g., very high-risk patients). Patient is on maximally tolerated therapy with at least two agents for coronary disease [e.g., antiplatelet (aspirin), lipid-lowering agent (statin [atorvastatin], ezetimibe, PCSK9 inhibitors [evolocumab]), beta-blocker (atenolol) or renin-angiotensin-aldosterone system blockers (lisinopril)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LONSURF (S)

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND One of the following: Used as a single agent or Used in combination with bevacizumab AND Patient has been previously treated with both of the following: A) fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND B) anti-VEGF therapy (e.g., Avastin [bevacizumab]) AND One of the following: A) patient has RAS wild-type tumors and patient has been previously treated with one anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]) OR Patient has RAS mutant tumors. Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Patient has been previously treated with two of the following: fluropyrimidine-based chemotherapy (e.g. fluorouracil), Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LOPRESSOR ORAL SOLUTION (S)

Products Affected

- Lopressor SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: a) Hypertension, b) Angina Pectoris, or c) Myocardial Infarction. One of the following: a) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), or b) Dosage requirements cannot be met with a solid dosage form.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LOQTORZI (S)

Products Affected

- Loqtorzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of nasopharyngeal carcinoma (NPC). Disease is one of the following: A) metastatic, or B) recurrent and locally advanced. One of the following: A) Both of the following: 1) Loqtorzi is being used as first line treatment, and 2) Loqtorzi is being used in combination with cisplatin and gemcitabine, or B) Both of the following: 1) Loqtorzi is being used as recurrent NPC treatment, and 2) Disease has progressed on or after a platinum containing chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LORBRENA (S)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LOTRONEX (S)

Products Affected

- Alosetron Hydrochloride
- Lotronex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Severe Diarrhea-Predominant Irritable Bowel Syndrome (IBS) in Women (initial): All of the following: 1) diagnosis of severe diarrhea-predominant IBS, 2) symptoms for at least 6 months, 3) female patient, AND 4) trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	Initial: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	IBS (initial): 12 weeks. IBS (reauth): 6 mo.
Other Criteria	IBS (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy (e.g., relief of IBS abdominal pain and discomfort, improvement in stool consistency and frequency, improvement as measured by the Global Improvement Scale).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUCENTIS (S)

Products Affected

- Lucentis SOSY

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: (Lucentis 0.5 mg) One of the following diagnoses: A) Neovascular (wet) age-related macular degeneration, B) Macular edema following retinal vein occlusion, OR C) Myopic choroidal neovascularization. (Lucentis 0.3 mg) One of the following diagnoses: A) Diabetic macular edema, OR B) Diabetic retinopathy
Age Restrictions	N/A
Prescriber Restrictions	All strengths/Indications (Initial): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases
Coverage Duration	All Strengths/Indications (Initial, Reauth): 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUMAKRAS (S)

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced or b) metastatic. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy). Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. Presence of KRAS G12C-mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received prior therapy with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy. Used in combination with Vectibix (panitumumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUMIZYME (S)

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Infantile Onset Pompe Disease (IOPD) (initial): Diagnosis of IOPD (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: 1) Absence or deficiency (less than 1% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay, OR 2) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., cardiomegaly, hypotonia, etc.). Late Onset Pompe Disease (LOPD) (initial): Diagnosis of LOPD (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: 1) Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay, OR 2) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.).
Age Restrictions	IOPD (initial): Patient is less than or equal to 12 months of age. LOPD (initial): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	IOPD, LOPD (initial, reauth): 12 months
Other Criteria	IOPD, LOPD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUMRYZ (S)

Products Affected

- Lumryz
- Lumryz Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND One of the following: a) patient is under 18 years of age or b) trial and failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
Age Restrictions	All Indications (initial): Patient is 7 years of age or older.
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUNSUMIO (S)

Products Affected

- Lunsumio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUNSUMIO VELO (S)

Products Affected

- Lunsumio Velo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPKYNIS (S)

Products Affected

- Lupkynis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lupus Nephritis (initial): Diagnosis of active lupus nephritis. Used in combination with immunosuppressive therapy (e.g., mycophenolate mofetil, methylprednisolone).
Age Restrictions	N/A
Prescriber Restrictions	Lupus Nephritis (initial): Prescribed by or in consultation with a nephrologist or rheumatologist
Coverage Duration	Lupus Nephritis (initial, reauth): 12 months
Other Criteria	Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPRON (S)

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUPRON DEPOT (S)

Products Affected

- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Diagnosis of advanced or metastatic prostate cancer. Endometriosis (3.75 mg, 11.25 mg): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or trial and failure, contraindication, or intolerance to one NSAID (e.g., diclofenac, ibuprofen, meloxicam, naproxen) and one oral contraceptive (e.g., norethindrone-ethinyl estradiol, estradiol and norethindrone). Uterine Leiomyomata (UL) (3.75 mg, 11.25 mg): a) For use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) OR b) all of the following: treatment of anemia, anemia is caused by uterine leiomyomata (fibroids), and for use prior to surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA: 12 mo. Endomet:6mo. UL (anemia):3 mo (fibroids):4 mo
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUPRON DEPOT PED (S)

Products Affected

- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Lupron Depot-ped (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYMPHIR (S)

Products Affected

- Lymphir

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYNKUET (S)

Products Affected

- Lynkuet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms (VMS) (initial): Diagnosis of moderate to severe VMS due to menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	VMS (initial, reauth): 6 months.
Other Criteria	VMS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYNPARZA TABLET (S)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Prostate cancer: Diagnosis of castration-resistant prostate cancer. All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYTGOBI (S)

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of intrahepatic cholangiocarcinoma. Disease is one of the following: a) unresectable, b) locally advanced, or c) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. Patient has been previously treated (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MARGENZA (S)

Products Affected

- Margenza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MARINOL (S)

Products Affected

- Dronabinol CAPS
- Marinol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 12 months.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAVENCLAD (S)

Products Affected

- Cladribine TBPK
- Mavenclad

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (e.g., relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Patient has not been previously treated with cladribine AND Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya fingolimod)], OR 2) Patient has previously received treatment with cladribine AND Patient has not already received the FDA-recommended lifetime limit of 2 treatment courses (or 4 treatment cycles total) of cladribine. Not used in combination with another disease-modifying therapy for MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist
Coverage Duration	MS: 2 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAVYRET (S)

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: 1) One of the following: a) Diagnosis of hepatitis C, or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of hepatitis C, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	One of the following: 1) Non-transplant patient who is treatment-naïve without decompensation, or 2) Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	8 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MAYZENT (S)

Products Affected

- Mayzent
- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKINIST (S)

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E or V600K mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Tafinlar (dabrafenib).Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Tafinlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic ATC. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Tafinlar (dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafinlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafinlar (dabrafenib).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEKTOVI (S)

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEPSEVII (S)

Products Affected

- Mepsevii

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

METFORMIN IR (S)

Products Affected

- Metformin Hydrochloride TABS 625MG, 750MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) History of greater than or equal to 12 week trial of another metformin immediate-release strength (e.g., 500mg, 850mg, 1000mg) OR b) Documented history of intolerance to another metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

METHOTREXATE INJECTION (S)

Products Affected

- Rasuvo INJ 10MG/0.2ML, 12.5MG/0.25ML, 15MG/0.3ML, 17.5MG/0.35ML, 20MG/0.4ML, 22.5MG/0.45ML, 25MG/0.5ML, 30MG/0.6ML, 7.5MG/0.15ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA) (initial): Diagnosis of active PJIA. Psoriasis (initial): Diagnosis of severe psoriasis. All Indications (initial): Trial of or intolerance to oral methotrexate.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA (initial): Prescribed by or in consultation with a rheuamtologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All Indications (Initial, reauth): 12 months
Other Criteria	All Indications (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

METHOTREXATE INJECTION, NON-PREFERRED (S)

Products Affected

- Otrexup INJ 10MG/0.4ML, 12.5MG/0.4ML, 15MG/0.4ML, 17.5MG/0.4ML, 20MG/0.4ML, 22.5MG/0.4ML, 25MG/0.4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA) (initial): Diagnosis of active PJIA. Psoriasis (initial): Diagnosis of severe psoriasis. All Indications (initial): Trial of or intolerance to oral methotrexate and Rasuvo.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA (initial): Prescribed by or in consultation with a rheuamtologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All Indications (Initial, reauth): 12 months
Other Criteria	All Indications (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

METHYLTESTOSTERONE (S)

Products Affected

- Methitest
- Methyltestosterone CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC: 12 mo. DP: 6 mo.

Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MIGRANAL (S)

Products Affected

- Dihydroergotamine Mesylate NASAL SOLN
- Migranal

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MIPLYFFA (S)

Products Affected

- Miplyffa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Niemann-Pick disease type C (NPC). Diagnosis is confirmed by one of the following: a) Genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2, or b) Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (greater than 2 times upper limit of normal). Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia). Requested drug will be used in combination with miglustat. Requested drug will not be used in combination with Aqneursa (levacetylleucine).
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will be used in combination with miglustat. Requested drug will not be used in combination with Aqneursa (levacetylleucine).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MIRVASO (S)

Products Affected

- Brimonidine Tartrate GEL
- Mirvaso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rosacea (init): Diagnosis of rosacea. Patient has moderate to severe persistent (nontransient) facial erythema.
Age Restrictions	Rosacea (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Rosacea (init, reauth): 12 months
Other Criteria	Rosacea (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MODEYSO (S)

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of diffuse midline glioma. Disease is confirmed by the presence of H3 K27M mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MONJUVI (S)

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MOUNJARO (S)

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MS INTERFERONS (NON-PREFERRED) (S)

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to one of the following: Avonex (interferon beta-1a) or Betaseron (interferon beta-1b), or 2) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MS INTERFERONS (PREFERRED) (S)

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen
- Betaseron
- Extavia
- Plegridy
- Plegridy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MULPLETA (S)

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Baseline platelet count is less than 50,000/mcL. Patient has chronic liver disease and is scheduled to undergo a procedure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MVASI (S)

Products Affected

- Mvasi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MYALEPT (S)

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy. One of the following: 1) Diabetes mellitus or insulin resistance despite insulin therapy at maximum tolerated doses OR 2) Hypertriglyceridemia.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Lipodystrophy (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MYCAPSSA (S)

Products Affected

- Mycapssa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) Inadequate response to surgical resection and/or pituitary irradiation, or 2) Patient is not a candidate for surgical resection or pituitary irradiation. Patient has responded to and tolerated treatment with octreotide or lanreotide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acromegaly (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MYFEMBREE (S)

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Uterine Leiomyomas (Fibroids) (initial): Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (initial): Diagnosis of moderate to severe pain associated with endometriosis. Patient is premenopausal. One of the following: 1) History of inadequate pain control response following a trial of 30 days, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progestin) contraceptive, or progestins or 2) Patient has had surgical ablation to prevent recurrence. Treatment duration of Myfembree has not exceeded a total of 24 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Indications (initial, reauth): 12 months.
Other Criteria	Uterine Leiomyomas (Fibroids) (reauth): Patient demonstrates positive clinical response to therapy. Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (reauth): Patient demonstrates positive clinical response to therapy. Treatment duration of Myfembree has not exceeded a total of 24 months.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MYLOTARG (S)

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MYOBLOC (S)

Products Affected

- Myobloc

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Chronic Sialorrhea (CS) (init): Diagnosis of chronic sialorrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CD/CS (init): 3 months, (reauth): 12 months.
Other Criteria	CD/CS (reauth): Patient demonstrates positive clinical response to therapy. At least 3 months has elapsed since the last treatment
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MYQORZO (S)

Products Affected

- Myqorzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of obstructive hypertrophic cardiomyopathy (HCM). Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain). Both of the following were measured prior to Myqorzo therapy: a) Patient had a left ventricular ejection fraction of greater than or equal to 55% and b) Patient had a valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation. Trial and failure, contraindication, or intolerance to one of the following at a maximally tolerated dose: a) non-vasodilating beta blocker (e.g., bisoprolol, propranolol) and b) calcium channel blocker (e.g., verapamil, diltiazem). Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Camzyos).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 6 months Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Patient has a left ventricular ejection fraction of greater than or equal to 50%. Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Camzyos).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NAGLAZYME (S)

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis (MPS VI): Diagnosis of MPS VI (Maroteaux-Lamy Syndrome).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MPS VI: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NAPROSYN (S)

Products Affected

- Naprosyn SUSP
- Naproxen SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Used for the relief of one of the following: Rheumatoid arthritis, Osteoarthritis, Ankylosing spondylitis, Polyarticular juvenile idiopathic arthritis, Tendonitis, Bursitis, Acute gout, Primary dysmenorrhea, or Pain management. One of the following: A) Trial and failure of generic enteric coated naproxen tablet, or B) One of the following: 1) Patient is unable to swallow solid oral dosage forms (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube) or 2) dosage requirements cannot be met with a solid dosage form).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEMLUVIO (S)

Products Affected

- Nemluvio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prurigo Nodularis (PN) (Initial): Diagnosis of PN. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to Dupixent (dupilumab), or b) For continuation of prior therapy. Atopic Dermatitis (AD) (Initial): Diagnosis of moderate to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing AD (SCORAD) index value of at least 25. Will be used in combination with topical corticosteroids and/or calcineurin inhibitors. TF/C/I to two of the following: Adbry (tralokizumab-ldrm), Dupixent, Ebglyss (lebrikizumab-lbkz), or Rinvoq (upadacitinib).
Age Restrictions	AD (Initial): Patient is 12 years of age or older.
Prescriber Restrictions	AD, PN (Initial): Prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist.
Coverage Duration	AD, PN (Initial): 6 months. Reauth: 12 months.
Other Criteria	PN (Reauth): Patient demonstrates positive clinical response to therapy. AD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) reduction in BSA involvement from baseline, or b) a reduction in SCORAD index value from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEREUS (S)

Products Affected

- Nereus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Used for the short-term prevention of vomiting induced by motion. Dosing frequency will be limited to once daily dosing. Trial and failure, contraindication, or intolerance to two conventional motion sickness therapies including but not limited to the following: transdermal scopolamine and antihistamines (e.g., dimenhydrinate, meclizine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NERLYNX (S)

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Early Stage Breast cancer: Diagnosis (dx) of early stage breast cancer. Advanced or Metastatic Breast Cancer: Dx of advanced or metastatic breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEULASTA (S)

Products Affected

- Neulasta
- Neulasta Onpro Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXAVAR (S)

Products Affected

- Nexavar
- Sorafenib
- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC. One of the following: locally recurrent disease, or metastatic disease. Patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXLETOL (S)

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous familial hypercholesterolemia (HeFH), Hypercholesterolemia, or Prevention of Cardiovascular (CV) Events in patients at increased risk for major adverse cardiovascular events (Initial): One of the following diagnoses: A) HeFH, B) Hypercholesterolemia, C) At increased risk for a major adverse CV event. One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) or pt has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXLIZET (S)

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Heterozygous familial hypercholesterolemia (HeFH), Hypercholesterolemia, or Prevention of Cardiovascular (CV) Events in patients at increased risk for major adverse cardiovascular events (Initial): One of the following diagnoses: A) HeFH, B) Hypercholesterolemia, C) At increased risk for a major adverse CV event (e.g., cardiovascular death, myocardial infarction, stroke, or coronary revascularization). One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 70 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy, 2) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Patient has a contraindication to all statins.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Patient continues to receive other lipid-lowering tx (eg statins, ezetimibe) or patient has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXVIAZYME (S)

Products Affected

- Nexviazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Late-onset Pompe disease (LOPD) (initial): Diagnosis of LOPD (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: 1) Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay, OR 2) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.).
Age Restrictions	LOPD (initial): Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	LOPD (initial, reauth): 12 months.
Other Criteria	LOPD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NGENLA (S)

Products Affected

- Ngenla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pediatric Growth Hormone Deficiency (PGHD) (initial): Both of the following: 1) Diagnosis of PGHD as confirmed by one of the following: a) Height is documented by one of the following (utilizing age and gender growth charts related to height): i) height is greater than 2.0 standard deviations (SD) below midparental height, or ii) height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender), b) Growth velocity is greater than 2 SD below mean for age and gender, or c) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (eg, delayed greater than 2 years compared with chronological age), AND 2) Documentation of one of the following: a) Patient is male with bone age less than 16 years, or b) Patient is female with bone age less than 14 years. Trial and failure or intolerance to Genotropin.
Age Restrictions	PGHD (initial): Patient is 3 years of age or older.
Prescriber Restrictions	PGHD (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	PGHD (initial, reauth): 12 months.
Other Criteria	PGHD (reauth): Both of the following: A) Expected adult height not attained, AND B) Documentation of expected adult height goal.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NIKTIMVO (S)

Products Affected

- Niktimvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic graft versus host disease (cGVHD). Trial and failure of at least two other systemic therapies [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate]. Patient weighs at least 40kg.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient does not show evidence of progressive disease while on therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NILOTINIB (S)

Products Affected

- Nilotinib D-tartrate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NINLARO (S)

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NON-PREFERRED TIRF (S)

Products Affected

- Fentanyl Citrate TABS 100MCG, 200MCG
- Fentora TABS 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, Oral hydrocodone at a dose of greater than or equal to 60 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day). Trial and failure or intolerance to generic fentanyl lozenge.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NORTHERA (S)

Products Affected

- Droxidopa
- Northera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurogenic orthostatic hypotension (NOH) (init): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial and failure, contraindication, or intolerance to one of the following agents: fludrocortisone acetate, midodrine.
Age Restrictions	N/A
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist
Coverage Duration	NOH (init): 1 month (reauth): 12 months
Other Criteria	NOH (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NOURIANZ (S)

Products Affected

- Nourianz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing "off" episodes. Medication will be used in combination with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B Inhibitor (e.g., rasagiline, selegiline), Dopamine Agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
Age Restrictions	N/A
Prescriber Restrictions	PD (initial): Prescribed by or in consultation with a neurologist
Coverage Duration	PD (initial, reauth): 12 months
Other Criteria	PD (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with carbidopa/levodopa.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NOVANTRONE (S)

Products Affected

- Mitoxantrone Hydrochloride INJ 25MG/12.5ML, 2MG/ML, 30MG/15ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis (dx) of one of the following: secondary progressive MS: gradually worsening disability with or without superimposed relapses, progressive relapsing MS: progression of disability from the onset with superimposed relapses, or worsening relapsing-remitting MS: neurological status remains significantly abnormal in between MS relapses. Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS (e.g., Gilenya [fingolimod], Avonex [interferon beta-1a], Betaseron [interferon beta-1b]). Left ventricular ejection fraction (LVEF) greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Lifetime cumulative dose less than 140 mg/m^2. Prostate Cancer (PC): Dx of advanced hormone-refractory (castration-resistant) PC. Used in combination with corticosteroids (eg, prednisone, methylprednisolone). LVEF greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Acute Non-Lymphocytic Leukemia (ANLL): Dx of ANLL (eg, myelogenous, promyelocytic, monocytic, and erythroid). Used in combination with other medications used for the treatment of ANLL. LVEF greater than or equal to 50%.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Uses: 6 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NOXAFIL POWDERMIX (S)

Products Affected

- Noxafil PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Patient weighs 40 kg or less. Treatment (Tx) of SFI: Used as Tx of SFI caused by Aspergillus. Patient weighs between 10 kg to 40 kg.
Age Restrictions	All indications: Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All indications: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NOXAFIL SUSPENSION (S)

Products Affected

- Noxafil SUSP
- Posaconazole SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Oropharyngeal Candidiasis (OPC): Diagnosis of OPC. One of the following: 1) Trial and failure, contraindication, or intolerance to fluconazole OR 2) Susceptibility results demonstrate resistance to fluconazole.
Age Restrictions	Prophylaxis of SFI, OPC: Patient is 13 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months. OPC: 1 month.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NPLATE (S)

Products Affected

- Nplate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune thrombocytopenia (ITP): Diagnosis of one of the following: a) ITP or b) relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., dexamethasone, prednisone), immune globulins (e.g., Gammaplex, Gammagard S/D), or splenectomy. Hematopoietic syndrome of acute radiation syndrome: Diagnosis of hematopoietic syndrome of acute radiation syndrome. Patient is acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial), Hematopoietic syndrome of acute radiation syndrome: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP (initial, reauth): 12 months. Hematopoietic syndrome of acute radiation syndrome: 14 days.
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUBEQA (S)

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic Castration-sensitive prostate cancer (mCSPC): Diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) [also known as metastatic hormone-sensitive prostate cancer (mHSPC)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, mCSPC: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NUCALA (S)

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by one of the following: baseline(pre-tx) peripheral blood eosinophil level is greater than or equal to 150cells/ml or peripheral blood eosinophil levels were greater than or equal to 300cells/ml within the past 12 mo. Patient has had two or more asthma exacerbations requiring systemic corticosteroids(eg, prednisone) within the past 12 mo or Patient has had a prior asthma-related hospitalization within the past 12 mo. One of the following: 1)Both of the following: a)Patient is 6 years of age or older but less than 12 years of age b)Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i)Medium-dose inhaled corticosteroid[ICS](eg, greater than 100-200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]) or ii)One medium dosed combination ICS/LABA product (eg, Wixela Inhub[fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone furoate 50 mcg/vilanterol 25 mcg]) OR Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a)Both of the following: i)High-dose ICS(eg, greater than 500 mcg fluticasone propionate equivalent/day) and ii)additional asthma controller medication(eg, leukotriene receptor antagonist[LTRA][eg, montelukast], long-acting beta-2 agonist[LABA][eg, salmeterol], long-acting muscarinic antagonist[LAMA][eg, tiotropium]), OR b)One maximally-dosed combination ICS/LABA product(eg, Wixela Inhub[fluticasone propionate 500mcg/salmeterol 50mcg], budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta[fluticasone 200mcg/vilanterol 25mcg])

Age Restrictions	N/A
Prescriber Restrictions	Asthma (init): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist.
Coverage Duration	Asthma, COPD (init): 6 mo, (reauth): 12 months. CRSwNP, EGPA, HES (init, reauth): 12 months
Other Criteria	Hypereosinophilic Syndrome (HES) (init): Diagnosis (dx) of HES. Patient (Pt) has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Pt is FIP1L1-PDGFRA-negative. Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication (CI), or intolerance to corticosteroid (CS) therapy (tx) (e.g., prednisone) or cytotoxic/immunosuppressive tx (e.g., hydroxyurea, cyclosporine, imatinib). Asthma (reauth): Pt demonstrates positive clinical response to tx. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Dx of CRSwNP. Unless CI, the pt has had an inadequate response to 2 months of treatment with an intranasal CS (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Dx of EGPA. Pt's disease has relapsed or is refractory to standard of care tx (i.e., CS treatment with or without immunosuppressive tx). Pt is currently receiving CS tx (e.g., prednisolone, prednisone) unless there is a CI or intolerance to CS tx. CRSwNP (reauth): Pt demonstrates positive clinical response to tx. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Pt demonstrates positive clinical response to tx. Chronic Obstructive Pulmonary Disease (COPD) (init): Dx of COPD. Presence of Type 2 inflammation evidenced by 1 of the following: a) Blood eosinophils greater than or equal to 150 cells/microliter at baseline, or b) Blood eosinophils greater than or equal to 300 cells/microliter in the last 12 months. Pt is receiving 1 of the following: a) Triple tx (i.e., ICS, LAMA, and a LABA), or b) If CI to ICS, a LAMA and a LABA. Pt has had 1 of the following within the past 12 months: a) At least 2 exacerbations where systemic CS [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once, or b) COPD-related hospitalization. COPD (reauth): Pt demonstrates positive clinical response to tx. Pt continues to receive 1 of the following tx: a) Triple tx (i.e., ICS, LAMA, and LABA, or b) If CI to ICS, a LAMA and a LABA.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUEDEXTA (S)

Products Affected

- Dextromethorphan Hydrobromide/quinidine Sulfate
- Nuedexta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. Patient does not have any of the following contraindications: a) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block.
Age Restrictions	N/A
Prescriber Restrictions	PBA (initial): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist.
Coverage Duration	PBA (initial/reauth): 12 months
Other Criteria	PBA (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NULIBRY (S)

Products Affected

- Nulibry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Both of the following: a) Diagnosis of molybdenum cofactor deficiency (MoCD) Type A AND b) Genetic mutation in the MOCS1 gene. Patient has clinical and/or laboratory signs and symptoms consistent with MOCD Type A (e.g., seizures, limb/axial hypertonia, elevated levels of urinary sulfite/SSC [s-sulfocysteine] or xanthine in blood/urine, low uric acid in blood/urine).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient continues to benefit from medication
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NUPLAZID (S)

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NURTEC (S)

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Treatment of Migraine (initial): Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	All Indications (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Acute Treatment (init): 12mo. Preventive Treatment (init): 6mo. All Indications (reauth): 12mo.
Other Criteria	Preventive Treatment of Episodic Migraine (EM) (initial): Both of the following: 1) Diagnosis of EM and 2) Patient has greater than or equal to 4 migraine days per month. Acute Treatment of Migraine (reauth): Patient has experienced a positive response to therapy. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines. Preventive Treatment of EM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUVIGIL (S)

Products Affected

- Armodafinil
- Nuvigil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: 12 mo

Other Criteria	OSA, Narcolepsy (Reauth): Patient demonstrates positive clinical response to armodafinil therapy. SWD (Reauth): Patient demonstrates positive clinical response to armodafinil therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NYVEPRIA (S)

Products Affected

- Nyvepria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta AND Udenyca.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OCALIVA (S)

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Biliary Cholangitis (PBC) (initial): Diagnosis of PBC (aka primary biliary cirrhosis). One of the following: a) patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND used in combination with ursodeoxycholic acid (UDCA), OR b) history of contraindication or intolerance to ursodeoxycholic acid (UDCA). Requested drug will not be used in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar). Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).
Age Restrictions	N/A
Prescriber Restrictions	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	PBC (initial): 6 months, (reauth): 12 months
Other Criteria	PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in ALP level from pre-treatment baseline (ie, prior obeticholic acid therapy) while on therapy. Requested drug will not be used in combination with Iqirvo (elafibranor) or Livdelzi (seladelpar). Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OCREVUS (S)

Products Affected

- Ocrevus
- Ocrevus Zunovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing forms of multiple sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesion). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to one disease-modifying therapies for MS (e.g., Avonex [interferon beta-1a], Betaseron [interferon beta-1b], Gilenya [fingolimod]) OR 2) For continuation of prior therapy. Primary progressive MS (PPMS) (initial): Diagnosis of PPMS. All uses (initial, reauth): Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]).
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a neurologist.
Coverage Duration	All uses (initial, reauth): 12 months.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ODACTRA (S)

Products Affected

- Odactra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Allergic rhinitis (AR) (Initial): Diagnosis of house dust mite (HDM)-induced allergic rhinitis. One of the following: 1) positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, OR 2) skin testing to licensed house dust mite allergen extracts. Trial and failure, contraindication, or intolerance to an intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, flunisolide nasal spray) AND an antihistamine (e.g., cetirizine, loratadine, azelastine nasal spray, olapatadine nasal spray).
Age Restrictions	AR (Initial): Patient is 5 to 65 years of age
Prescriber Restrictions	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	AR (initial, reauth): 12 months
Other Criteria	AR (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ODOMZO (S)

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma AND One of the following: 1) Cancer has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OFEV (S)

Products Affected

- Nintedanib Esylate
- Ofev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD as documented by all of the following: a) exclusion of other known causes of ILD (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on HRCT revealing SSc-ILD or probable SSc-ILD, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype (initial), Progressive Pulmonary Fibrosis (PPF): 1) diagnosis of chronic fibrosing interstitial lung disease or progressive pulmonary fibrosis (PPF), AND 2) patient has a high-resolution computed tomography (HRCT) showing fibrotic features, AND 3) disease has a progressive phenotype as observed by one of the following: decline of forced vital capacity (FVC), worsening of respiratory symptoms, or increased extent of fibrosis seen on imaging.
Age Restrictions	N/A

Prescriber Restrictions	All Indications (initial): Prescribed by or in consultation with a pulmonologist or a rheumatologist.
Coverage Duration	Initial, reauth: 12 months
Other Criteria	All Indications (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OGIVRI (S)

Products Affected

- Ogivri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OGSIVEO (S)

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OHTUVAYRE (S)

Products Affected

- Ohtuvayre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic obstructive pulmonary disease (COPD). Patient is symptomatic despite being on at least two therapies indicated for the treatment of COPD and will continue to be treated with the therapies (e.g., long acting muscarinic antagonists [e.g., tiotropium], long-acting beta agonist [e.g., formoterol]), unless there is a contraindication or intolerance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Part B vs D determination applies. Reauth: Patient demonstrates a positive clinical response to therapy. Patient continues to be treated with at least two therapies indicated for the treatment of COPD (e.g., long acting muscarinic antagonists [e.g., tiotropium], long-acting beta agonist [e.g., formoterol]), unless there is a contraindication or intolerance.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA (S)

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Disease has a BRAF fusion or rearrangement, or BRAF V600 mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJJAARA (S)

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Patient has anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OLPRUVA (S)

Products Affected

- Olpruva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Both of the following: 1) Diagnosis of urea cycle disorders (UCDs), and 2) One of the following deficiencies: a) carbamylphosphate synthetase (CPS), b) ornithine transcarbamylase (OTC), or c) argininosuccinic acid synthetase (AS). Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene. Inadequate response to one of the following: a) Dietary protein restriction, or b) Amino acid supplementation.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OMVOH (IV) (S)

Products Affected

- Omvoh INJ 300MG/15ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. One of the following: 1) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, one formulary ustekinumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), or Rinvoq (upadacitinib), OR 2) For continuation of prior therapy. Will be administered as an intravenous induction dose. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, erythrocyte sedimentation rate, C-reactive protein), OR dependent on, or refractory to, corticosteroids. One of the following: 1) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), OR 2) For continuation of prior therapy. Will be administered as an intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC: 3 months.
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OMVOH (S)

Products Affected

- Omvoh INJ 0, 100MG/ML, 200MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 6 months, (reauth): 12 months.
Other Criteria	CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONPATTRO (S)

Products Affected

- Onpattro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Presence of a transthyretin (TTR) mutation (e.g., V30M) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy). Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Age Restrictions	N/A
Prescriber Restrictions	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	hATTR amyloidosis (initial, reauth): 12 months.
Other Criteria	Subject to Part B vs D review. hATTR amyloidosis (reauth): Patient demonstrates postive clinical response to therapy. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONTRUZANT (S)

Products Affected

- Ontruzant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Trial and failure, or intolerance to both Kanjinti (trastuzumab-anns) and Trazimera (trastuzumab-qyyp).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ONUREG (S)

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML). Patient has received previous treatment with an intensive induction chemotherapy regimen (e.g., cytarabine + daunorubicin, cytarabine + idarubicin, etc.). Patient has achieved one of the following: a) first complete remission (CR) or b) complete remission with incomplete blood count recovery (CRi). Patient is not able to complete intensive curative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ONYDA (S)

Products Affected

- Onyda Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Patient is unable to swallow solid dosage forms (e.g., oral tablet, capsule). Trial and failure, contraindication, or intolerance to two of the following: a) generic atomoxetine, b) generic guanfacine ER, or c) generic clonidine ER.
Age Restrictions	Initial: Patient is less than 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPDIVO (S)

Products Affected

- Opdivo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPDIVO QVANTIG (S)

Products Affected

- Opdivo Qvantig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPDUALAG (S)

Products Affected

- Opdualag

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPFOLDA (S)

Products Affected

- Opfolda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency). Disease is confirmed by one of the following: a) Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay or b) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.). Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga). Patient weight is greater than or equal to 40 kg. Trial and inadequate response to one of the following: a) Lumizyme or b) Nexviazyme. Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga). Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPIPZA (S)

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of Schizophrenia. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: a) aripiprazole (failure or contraindication are not required), b) olanzapine, c) quetiapine IR/ER, d) risperidone, e) clozapine, f) ziprasidone, g) paliperidone, or h) asenapine. Major Depressive Disorder (MDD): Diagnosis of MDD. Both of the following: a) TF/C/I to quetiapine IR/ER and b) Trial of or intolerance to aripiprazole. Autism: Diagnosis of irritability associated with autistic disorder. Both of the following: a) Trial and failure, contraindication (e.g., age), or intolerance to risperidone and b) Trial of or intolerance to aripiprazole. Tourette's Syndrome: Diagnosis of Tourette's Syndrome. Trial of or intolerance to aripiprazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPSUMIT (S)

Products Affected

- Macitentan
- Opsumit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPZELURA (S)

Products Affected

- Opzelura

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Atopic Dermatitis (AD) Initial: Diagnosis of mild to moderate atopic dermatitis. One of the following: a) Greater than or equal to 3% body surface area (BSA) involvement, or b) Involvement of sensitive body areas (e.g., face, hands, feet, scalp, groin). Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least two of the following: a) Medium or higher potency topical corticosteroid, b) Elidel (pimecrolimus) cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. Opzelura will only be used for short-term and/or non-continuous chronic treatment. Nonsegmental Vitiligo (NV) Initial: Diagnosis of NV. Trial and failure, contraindication, or intolerance to at least one of the following: medium or higher potency topical corticosteroid or tacrolimus ointment. AD, NV (Initial, Reauth): Not used in combination with therapeutic biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine).
Age Restrictions	AD Initial: Patient is 2 years of age or older. NV Initial: Patient is 12 years of age or older.
Prescriber Restrictions	AD Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist. NV Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	AD Initial: 12 weeks. AD Reauth: 6 months. NV Initial: 6 months. NV Reauth: 12 months.
Other Criteria	AD Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, b) Reduction in pruritus severity from baseline, or c) Improvement in quality of life from baseline. Opzelura will only be used for short-term and/or non-continuous chronic treatment. NV Reauth: Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENCIA IV (S)

Products Affected

- Orencia INJ 250MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Acute graft versus host disease (aGVHD): Used for prophylaxis of aGVHD. Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT. Used in combination with both of the following: calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate.
Age Restrictions	aGVHD: Patient is 2 years of age or older
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	RA, JIA, PsA (initial): 6 months, (reauth): 12 months. aGVHD: 2 months

Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENCIA SC (S)

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML
- Orencia Clickject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENITRAM (S)

Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORGOVYX (S)

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORIAHNN (S)

Products Affected

- Oriahnn

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Treatment duration of therapy has not exceeded a total of 24 months.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORILISSA (S)

Products Affected

- Orilissa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (EM) (initial - 150 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence. EM (200 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	EM (init, reauth-150mg): 6 mo. EM (200mg): 6 mo.
Other Criteria	EM (reauthorization - 150 mg): Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain). Treatment duration has not exceeded a total of 24 months.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORKAMBI (S)

Products Affected

- Orkambi TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	CF (Initial): Patient is 6 years of age or older
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORKAMBI GRANULES (S)

Products Affected

- Orkambi PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.
Age Restrictions	N/A
Prescriber Restrictions	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORLADEYO (S)

Products Affected

- Orladeyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 2 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORLYNVAH (S)

Products Affected

- Orlynvah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of an uncomplicated urinary tract infection (uUTI). Trial and inadequate response, contraindication, or resistance to one alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin). Infection with one of the following: a) Escherichia coli, b) Klebsiella pneumoniae, or c) Proteus mirabilis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORSERDU (S)

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor (ESR1) mutation(s) as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OSENVELT (S)

Products Affected

- Osenvelt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Skeletal prevention in Multiple Myeloma (MM)/Bone Metastasis from Solid Tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (e.g., breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. One of the following: 1) One of the following: a) tumor is unresectable or b) surgical resection is likely to result in severe morbidity, OR 2) Approve for continuation of prior therapy. Hypercalcemia of malignancy (HCM): Diagnosis of hypercalcemia of malignancy. Trial and failure, contraindication, or intolerance to one bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MM/BMST, GCTB, HCM: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OSPHENA (S)

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Dyspareunia, Vaginal dryness (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OTEZLA (S)

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, OR calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Patient weighs at least 20 kg. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	Plaque psoriasis (initial): Patient is 6 years of age or older.
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OTEZLA XR (S)

Products Affected

- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, OR calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Patient weighs at least 50 kg. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
Age Restrictions	Plaque psoriasis (initial): Patient is 6 years of age or older.
Prescriber Restrictions	PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months.
Other Criteria	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OXERVATE (S)

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurotrophic keratitis (NK) (initial): Diagnosis of NK.
Age Restrictions	N/A
Prescriber Restrictions	NK (initial): Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	NK (initial): 8 weeks, (reauth): One 8-Week Approval
Other Criteria	NK (reauth): One of the following: 1) Both of the following: a) Provider attests patient is being treated for disease recurrence (e.g., new corneal damage following prior corneal healing), and b) Provider attests patient has not experienced treatment failure (e.g., patient has not experienced corneal healing after a previous course of Oxervate), OR 2) Provider attests treatment is for an eye that has not previously been treated with Oxervate.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OXLUMO (S)

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary Hyperoxaluria Type 1 (PH1) (initial): Diagnosis of PH1. Diagnosis has been confirmed by both of the following: 1) One of the following: a) Elevated urinary oxalate excretion, b) Elevated plasma oxalate concentration, or c) Spot urinary oxalate to creatinine molar ratio greater than normal for age, AND One of the following: 1) Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene OR 2) Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity.
Age Restrictions	N/A
Prescriber Restrictions	PH1 (initial, reauth): Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
Coverage Duration	PH1 (initial, reauth): 12 months.
Other Criteria	PH1 (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OZEMPIC (S)

Products Affected

- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM) Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). Metabolic dysfunction-associated steatohepatitis (MASH) Initial: Diagnosis of MASH, formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by one of the following: FibroScan-aspartate aminotransferase (FAST), MRI-aspartate aminotransferase (MAST), or liver biopsy. Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following: FibroScan, Fibrosis-4 index (FIB-4), or Magnetic Resonance Elastography (MRE).
Age Restrictions	N/A
Prescriber Restrictions	MASH (Initial): Prescribed by or in consultation with one of the following: gastroenterologist, endocrinologist, or hepatologist.
Coverage Duration	12 months
Other Criteria	DM (Reauth): Patient demonstrates positive clinical response to therapy. MASH (Reauth): Patient demonstrates positive response to therapy.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OZEMPIC TABLET (S)

Products Affected

- Ozempic TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PADCEV (S)

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PALFORZIA (S)

Products Affected

- Palforzia Initial Dose Escalation
- Palforzia Initial Dose Escalation 1-3 Years
- Palforzia Initial Dose Escalation 4-17 Years
- Palforzia Level 0
- Palforzia Level 1
- Palforzia Level 10
- Palforzia Level 11 (maintenance)
- Palforzia Level 11 (titration)
- Palforzia Level 2
- Palforzia Level 3
- Palforzia Level 4
- Palforzia Level 5
- Palforzia Level 6
- Palforzia Level 7
- Palforzia Level 8
- Palforzia Level 9

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Initial: Excluded if any of the following: 1) history of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease, 2) history of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months, OR 3) severe or poorly controlled asthma.
Required Medical Information	Initial: Diagnosis and clinical history of peanut allergy as confirmed by one of the following: a) a serum peanut-specific IgE level of greater than or equal to 0.35 kUA/L, b) a mean wheal diameter that is at least 3mm larger than the negative control on skin-prick testing for peanut, or c) an Ara h 2 sIgE level greater than or equal to 0.35 kUA/L. One of the following: 1) patient is 1 to 17 years of age and is in the initial dose escalation phase of therapy, OR 2) patient is 1 year of age and older and is in the up-dosing or maintenance phase of therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PALSONIFY (S)

Products Affected

- Palsonify

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of acromegaly. One of the following: 1) Patient has an inadequate response to surgery or 2) Patient is not a candidate for surgery.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PALYNZIQ (S)

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management (e.g., Kuvan [sapropterin]). One of the following: Patient has had a trial and failure or intolerance to Kuvan (sapropterin) or patient is not a candidate for Kuvan (sapropterin) therapy due to the presence of two null mutations in trans. Patient will have phenylalanine blood levels measured every 4 weeks until a maintenance dose is established and periodically thereafter.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PKU (initial, reauth): 12 months
Other Criteria	PKU (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PEGASYS (S)

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection. Chronic Hepatitis C: Diagnosis of chronic hepatitis C infection. Patient has compensated liver disease. One of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin).
Age Restrictions	N/A
Prescriber Restrictions	Chronic Hepatitis C: Prescribed by or in consultation with one of the following: hepatologist, gastroenterologist, infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	HepB, HepC: 48 wks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PEMAZYRE (S)

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced or metastatic. Disease is confirmed by the presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior line of therapy (e.g., chemotherapy). Myeloid/lymphoid neoplasms: Diagnosis of myeloid/lymphoid neoplasms (MLNs). Disease is relapsed or refractory. Disease is confirmed by the presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PENNSAID (S)

Products Affected

- Diclofenac Sodium TOPICAL SOLN 1.5%, 2%
- Pennsaid SOLN 2%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Osteoarthritis of the knees (initial): Diagnosis of osteoarthritis of the knees. Patient meets one of the following: 1) Trial and failure, contraindication or intolerance to at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen) OR 2) History of peptic ulcer disease/gastrointestinal bleed OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Osteoarthritis of the knees (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PERJETA (S)

Products Affected

- Perjeta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PHESGO (S)

Products Affected

- Phesgo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PIASKY (S)

Products Affected

- Piasky

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH). Patient weighs at least 40 kg. Trial and failure, contraindication, or intolerance to Ultomiris (ravulizumab).
Age Restrictions	Initial: Patient is 13 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIQRAY (S)

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer (BC): Diagnosis of advanced or metastatic BC. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Cancer is PIK3CA-mutated as detected by an FDA-approved test (therascreen PIK3CA RGQ PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIVYA (S)

Products Affected

- Pivya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of uncomplicated urinary tract infection (uUTI). Trial and inadequate response, contraindication, or resistance to one alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin). Infection is caused by one of the following: a) Escherichia coli, b) Proteus mirabilis, or c) Staphylococcus saprophyticus.
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	7 Days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POLIVY (S)

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POMALYST (S)

Products Affected

- Pomalidomide
- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM): Diagnosis of MM. Kaposi sarcoma (KS): One of the following: 1) Diagnosis of AIDS-related KS, OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POMBILITI (S)

Products Affected

- Pombiliti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency). Disease is confirmed by one of the following: a) Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay or b) Molecular genetic testing confirms mutations in the GAA gene. Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.). Medication is used in combination with Opfolda (miglustat). Patient weight is greater than or equal to 40 kg. Trial and inadequate response to one of the following: a) Lumizyme or b) Nexviazyme. Not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Medication is used in combination with Opfolda (miglustat). Not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PONVORY (S)

Products Affected

- Ponvory
- Ponvory 14-day Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PORTRAZZA (S)

Products Affected

- Portrazza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POSACONAZOLE TABLET (S)

Products Affected

- Noxafil TBEC
- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment (Tx) of SFI: Used as treatment of systemic fungal infections caused by Aspergillus.
Age Restrictions	All indications: Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All indications: 6 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POTELIGEO (S)

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PRALUENT (S)

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event (init): One of the following diagnoses: A) HeFH, B) ASCVD, OR C) Primary hyperlipidemia (HLD) or hypercholesterolemia, OR D) At increased risk for a major adverse CV event. One of the following: 1) Patient has been receiving highest tolerable dose of statin therapy, 2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (eg, creatine kinase), OR 3) Patient has an FDA labeled contraindication to all statins. HoFH (init): Diagnosis of HoFH as confirmed by one of the following: 1) Genetic confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2) untreated LDL greater than 400, AND either xanthoma before 20 yo or evidence of HeFH in both parents. One of the following: 1) Patient is receiving other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe).
Age Restrictions	HeFH (Initial): Patient is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months

Other Criteria	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event (reauth): Patient continues to receive other lipid-lowering therapy (eg, statins, ezetimibe) at max tolerated dose (unless patient has documented inability to take these medications). HoFH (reauth): One of the following: 1) Patient continues to receive other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe). HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse cardiovascular event/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROCYSBI (S)

Products Affected

- Procysbi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nephropathic cystinosis: Diagnosis of nephropathic cystinosis, confirmed by elevated leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene or demonstration of cysteine corneal crystals by slit lamp examination AND Trial and failure or intolerance to therapy with Cystagon (immediate-release cysteamine bitartrate).
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROMACTA (S)

Products Affected

- Eltrombopag Olamine
- Promacta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of one of the following: relapsed/refractory ITP, persistent ITP, or chronic ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, intolerance, contraindication to corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C-associated thrombocytopenia. One of the following: 1) Planning to initiate and maintain interferon-based treatment, or 2) currently receiving interferon-based treatment. First-line for severe aplastic anemia (SAA): Diagnosis of SAA. Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy). Used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine). Patient meets at least two of the following: 1) absolute neutrophil count less than 500/mcL, 2) platelet count less than 20,000/mcL, 3) absolute reticulocyte count less than 60,000/mcL. Refractory SAA (initial): Diagnosis of refractory SAA. Patient has one of the following: a) neutrophils less than 0.5 x 10^9/L, b) platelet count less than 30,000/mcL, or c) reticulocytes less than 60 x 10^9/L. Insufficient response to immunosuppressive therapy.
Age Restrictions	N/A
Prescriber Restrictions	ITP and SAA: Prescribed by or in consultation with a hematologist/oncologist. Chronic hepatitis C associated thrombocytopenia: Prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.
Coverage Duration	ITP(init,reauth):12mo.HepC:3mo(init),12mo(reauth).1stline SAA:6mo.RefractSAA:16wk-init,12mo-reauth

Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hepatitis C (reauth): Patient currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROVENGE (S)

Products Affected

- Provenge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PROVIGIL (S)

Products Affected

- Modafinil TABS
- Provigil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) Symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy. Idiopathic Hypersomnia (Initial): Diagnosis of idiopathic hypersomnia as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy, MS Fatigue: Init, Reauth: 12 mo. All other indications: Init, Reauth: 6 mo.
Other Criteria	OSA, SWD, MS Fatigue, Narcolepsy, Idiopathic Hypersomnia (Reauth): Patient demonstrates positive clinical response to therapy. Depression (reauth): Patient demonstrates positive clinical response to modafinil therapy. Used as adjunctive therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PULMOZYME (S)

Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PYRUKYND (S)

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count). Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene: a) Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant AND b) Patients is not homozygous for the c.1436G to A (p.R479H) variant AND c) Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene. Hemoglobin is less than or equal to 10g/dL. Patient has symptomatic anemia or is transfusion dependent. Exclusion of other causes of hemolytic anemias (e. g., infections, toxins, drugs).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QALSODY (S)

Products Affected

- Qalsody

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis amyotrophic lateral sclerosis (ALS). Molecular genetic testing confirms mutation in the SOD1 gene. Patient's baseline functional ability has been documented prior to initiating treatment (e.g., speech, walking, climbing stairs, etc.). Patient has a percent (%) slow vital capacity (%SVC) greater than or equal to 50% at the start of treatment. Patient does not require permanent noninvasive ventilation or invasive ventilation.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS.
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Patient demonstrates slowed disease progression from baseline.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QINLOCK (S)

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): Diagnosis of gastrointestinal stromal tumor (GIST). Disease is advanced. Patient has received prior treatment with three or more kinase inhibitors (e.g., sunitinib, regorafenib), one of which must include imatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QLOSI (S)

Products Affected

- Qlosi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of presbyopia.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QUALAQUIN (S)

Products Affected

- Qualaquin
- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used solely for the treatment or prevention of nocturnal leg cramps.
Required Medical Information	Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QULIPTA (S)

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraine (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (init): 6mo. EM, CM (reauth): 12mo.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QUTENZA (S)

Products Affected

- Qutenza
- Qutenza (2 Patch)
- Qutenza (4 Patch)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuropathic pain associated with postherpetic neuralgia (PHN) (initial): Diagnosis of neuropathic pain associated with postherpetic neuralgia and trial and failure, contraindication, or intolerance with generic lidocaine 5% patch. Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet (initial): Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet. Trial and failure, contraindication, or intolerance to generic lidocaine 5% patch.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PHN/DPN (Initial, reauth): 3 months
Other Criteria	PHN/DPN (reauth): It has been at least 3 months since the last application/administration. Patient experienced pain relief with a prior course of therapy. Patient is experiencing a return of neuropathic pain.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QUVIVIQ (S)

Products Affected

- Quviviq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance. Trial and failure, contraindication, or intolerance to Belsomra. One of the following: 1) Patient is 65 years of age or older, OR 2) Both of the following: a) Patient is less than 65 years of age and b) Trial and failure, contraindication, or intolerance to one of the following: eszopiclone, temazepam, zaleplon, zolpidem, or zolpidem ER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RADICAVA (S)

Products Affected

- Edaravone
- Radicava

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic lateral sclerosis (ALS) (initial): Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support a diagnosis of "definite" or "probable" ALS per the revised El Escorial diagnostic criteria. Patient has scores of greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment. Patient has a percent forced vital capacity (%FVC) of greater than or equal to 80% at the start of treatment.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	ALS (reauthorization): Patient demonstrates positive response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RADICAVA ORS (S)

Products Affected

- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic lateral sclerosis (ALS) (initial): Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support a diagnosis of "definite" or "probable" ALS per the revised El Escorial diagnostic criteria. Patient has scores of greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment. Patient has a percent forced vital capacity (%FVC) of greater than or equal to 80% at the start of treatment.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	ALS (reauthorization): Patient demonstrates positive response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RAVICTI (S)

Products Affected

- Glycerol Phenylbutyrate
- Ravicti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urea cycle disorders (UCDs) (Initial): Both of the following: 1) Diagnosis of UCD AND 2) One of the following deficiencies: a) carbamylphosphate synthetase (CPS), b) ornithine transcarbamylase (OTC), or c) argininosuccinic acid synthetase (AS). Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene. Inadequate response to one of the following: 1) Dietary protein restriction or 2) Amino acid supplementation.
Age Restrictions	N/A
Prescriber Restrictions	UCDs (initial): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
Coverage Duration	UCDs (Initial, reauth): 12 months
Other Criteria	UCDs (reauth): Patient demonstrates positive clinical response to therapy (e.g., plasma ammonia or amino acid levels within normal limits).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RAYOS (S)

Products Affected

- Prednisone Dr
- Rayos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Trial and failure, contraindication, or intolerance to one of the following formulary immediate-release oral steroids: cortisone, dexamethasone (eg, Dexamethasone Intensol), hydrocortisone (Cortef), methylprednisolone (Medrol), prednisolone (eg, Millipred, Orapred ODT), prednisone (eg, Prednisone Intensol).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Subject to BvD review.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REBLOZYL (S)

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Beta Thalassemia (initial): One of the following: a) Diagnosis of beta thalassemia major AND patient requires regular red blood cell (RBC) transfusions, OR b) Diagnosis of transfusion-dependent beta thalassemia. MDS-RS, MDS/MPN-RS-T (initial): One of the following diagnoses: a) Very low-to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS), OR b) Myelodysplastic or myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T). Patient has failed an erythropoiesis stimulating agent [e.g., Epogen (epoetin alfa), Aranesp (darbepoetin)]. Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks. MDS (initial): Diagnosis of very low- to intermediate-risk myelodysplastic syndromes (MDS). Patient does not have previous erythropoiesis stimulating agent use (ESA-naïve). Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Beta Thalassemia (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduction in RBC transfusion burden). MDS-RS, MDS/MPN-RS-T, MDS (reauth): Patient demonstrates positive clinical response to therapy (e.g., RBC transfusion independence, improvement in hemoglobin levels).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RECORLEV (S)

Products Affected

- Recorlev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Cushing's syndrome. Patient is being treated for endogenous hypercortisolemia (e.g., pituitary adenoma, ectopic tumor, adrenal adenoma). One of the following: 1) Patient is not a candidate for surgery, OR 2) Surgery has not been curative. Trial and failure of at least 30 days, or intolerance to oral ketoconazole.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REDEMPLO (S)

Products Affected

- Redemplo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia). One of the following: a) Disease is confirmed by the presence of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), b) A North American FCS (NAFCS) Score of greater than or equal to 45, or c) A Moulin score greater than 10.Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug. Requested drug will not be used in combination with Tryngolza (olezarsen).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or lipid specialist (lipidologist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug will not be used in combination with Tryngolza (olezarsen).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REGRANEX (S)

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diabetic neuropathic ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RELGAABI (S)

Products Affected

- Gabapentin CAPS 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of postherpetic neuralgia or partial onset seizures. Trial or intolerance to generic gabapentin (generic Neurontin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RELYVRIO (S)

Products Affected

- Relyvrio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of amyotrophic lateral sclerosis (ALS). Diagnosis of ALS is further supported by neurogenic changes in electromyography (EMG). Patient has had ALS symptoms for less than or equal to 18 months. Patient has a percent (%) forced vital capacity (%FVC) or slow vital capacity (%SVC) greater than or equal to 60% at the start of treatment. Patient does not require permanent noninvasive ventilation or invasive ventilation.
Age Restrictions	N/A
Prescriber Restrictions	ALS (initial, reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS.
Coverage Duration	Initial, Reauth: 6 months.
Other Criteria	Reauth: Patient demonstrates slowed disease progression from baseline.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REMICADE (S)

Products Affected

- Infliximab
- Remicade

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (Initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Ulcerative colitis (UC) (Initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine). Rheumatoid arthritis (RA) (Initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (Initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Prescriber Restrictions	CD, FCD, UC (initial): Prescribed by or in consultation with a gastroenterologist. RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months
Other Criteria	Ankylosing spondylitis (AS) (Initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (Initial): Dx of sarcoidosis. TF/C/I to both of the following: one immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine) AND one corticosteroid (eg, prednisone). Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REMODULIN (S)

Products Affected

- Remodulin
- Treprostinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	Subject to Part B vs. D Review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RENFLEXIS (S)

Products Affected

- Renflexis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (eg, prednisone), methotrexate. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, 6-mercaptopurine. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Used in combination with methotrexate. Psoriatic arthritis (PsA) (initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus).
Age Restrictions	N/A

Prescriber Restrictions	Initial: RA, AS: Prescribed by or in consultation with a rheumatologist. PsA: Prescribed or in consultation with a rheumatologist or dermatologist. Crohn's Disease, Fistulizing Crohn's Disease, UC: Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: Prescribed by or in consultation with a dermatologist. Sarcoidosis (initial): Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All indications (initial): 6 months, (reauth): 12 months.
Other Criteria	Ankylosing spondylitis (AS) (initial): Dx of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Sarcoidosis (initial): Dx of sarcoidosis. TF/C/I to one of the following: corticosteroid (eg, prednisone) OR immunosuppressant (eg, methotrexate, cyclophosphamide, azathioprine). Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the BSA involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Sarcoidosis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REPATHA (S)

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event (init): One of the following diagnoses: A) HeFH, B) ASCVD, C) Primary hyperlipidemia (HLD) or hypercholesterolemia, OR D) At increased risk for a major adverse CV event. One of the following: a) Patient has been receiving the highest tolerable dose of statin therapy, OR b) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (eg, creatine kinase), OR c) Patient has an FDA labeled contraindication to all statins. HoFH (init): Diagnosis of HoFH as confirmed by one of the following: 1) Genetic confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2) untreated LDL greater than 400, AND either xanthoma before 20 yo or evidence of HeFH in both parents. One of the following: 1) Patient is receiving other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe).
Age Restrictions	(Initial) HeFH/HoFH: 10 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months

Other Criteria	HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event (reauth): Patient continues to receive other lipid-lowering therapy (eg, statins, ezetimibe) at max tolerated dose (unless patient has documented inability to take these medications). HoFH (reauth): One of the following: 1) Patient continues to receive other lipid-lowering therapy (eg, statin, ezetimibe) or 2) Patient has a documented inability to take other lipid-lowering therapy (eg, statin, ezetimibe). HeFH/ASCVD/Primary HLD/Hypercholesterolemia/Prevention of Cardiovascular (CV) Events in patients at increased risk for a major adverse CV event/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RETACRIT (S)

Products Affected

- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial):Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon/peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa. Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
Other Criteria	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 months is 33% or less (Hgb is 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. Other Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Adequate iron stores confirmed by both of the following: a) Patient's ferritin level is greater than 100 mcg/L and b) Patient's transferrin saturation (TSAT) is greater than 20%.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RETEVMO (S)

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer: Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medullary Thyroid Cancer (MTC): Diagnosis of medullary thyroid cancer (MTC). Disease is advanced or metastatic. Disease has presence of RET gene mutation tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate. Solid Tumors: Diagnosis of solid tumors. Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). ONE of the following: a) Disease has progressed on or following prior systemic treatment (e.g., chemotherapy), OR b) There are no satisfactory alternative treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Non-Small Cell Lung Cancer, MTC, Thyroid Cancer, Solid Tumors: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVATIO (S)

Products Affected

- Revatio TABS
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVATIO INJECTION (S)

Products Affected

- Revatio INJ
- Sildenafil INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Patient is unable to take oral medications.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVATIO SUSPENSION (S)

Products Affected

- Liqrev
- Revatio SUSR
- Sildenafil Citrate SUSR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVCOVI (S)

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVLIMID (S)

Products Affected

- Lenalidomide
- Revlimid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Myelodysplastic syndromes (MDS): Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q. Mantle cell lymphoma (MCL): Diagnosis of MCL. Follicular Lymphoma (FL): Diagnosis of FL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVUFORJ (S)

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute leukemia: Diagnosis of acute leukemia. Disease is relapsed or refractory. Presence of lysine methyltransferase 2A gene (KMT2A) translocation. Acute myeloid leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. One of the following: 1) Presence of a lysine methyltransferase 2A gene (KMT2A) translocation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR 2) Presence of a susceptible nucleophosmin 1 (NPM1) mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REYVOW (S)

Products Affected

- Reyvow

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Patient has less than 15 headache days per month. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 8 hours after taking each dose of Reyvow.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Will not be used for preventive treatment of migraine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REZDIFFRA (S)

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH). Patient does not have cirrhosis (e.g., decompensated cirrhosis). Disease is fibrosis stage F2 or F3 as confirmed by one of the following: 1) Both of the following: A) Serum biomarker [e.g., enhanced liver fibrosis (ELF) test, fibrosis-4 index (FIB-4)], and B) Imaging biomarker [e.g., FibroScan, magnetic resonance imaging-proton density fat fraction (MRI-PDFF)], or 2) One of the following: A) FibroScan aspartate aminotransferase (FAST), B) MRI-aspartate aminotransferase (MAST), C) Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB), or D) Liver biopsy within the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: gastroenterologist, endocrinologist, or hepatologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive response to therapy. Patient has not progressed to cirrhosis.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZLIDHIA (S)

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1(IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZUROCK (S)

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate, chemotherapy].
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	cGVHD (initial, reauth): 12 months
Other Criteria	cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RHAPSIDO (S)

Products Affected

- Rhapsido

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic spontaneous urticaria (CSU) (initial): Diagnosis of CSU. Both of the following: a) Persistent symptoms (itching and hives) despite concurrent use of a second generation H1 antihistamine (eg, cetirizine, fexofenadine), unless there is a contraindication or intolerance (C/I) to H1 antihistamines and b) Minimum 2-week trial of up-dosing (eg, up to 4x dose) of the second generation H1 antihistamine, unless there is a C/I to H1 antihistamines. Will be used concurrently with a second generation H1 antihistamine, unless there is a C/I to H1 antihistamines. Trial and failure, contraindication, or intolerance to Dupixent (dupilumab) or Xolair (omalizumab).
Age Restrictions	N/A
Prescriber Restrictions	CSU (initial): Prescribed by or in consultation with an allergist/immunologist or dermatologist.
Coverage Duration	CSU (initial, reauth): 12 months.
Other Criteria	CSU (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction from baseline in itching severity or the number of hives.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RIABNI (S)

Products Affected

- Riabni

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma (NHL): One of the following: 1) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Used as first-line treatment in combination with chemotherapy, 2) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy. Used as monotherapy for maintenance therapy, 3) Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma. One of the following: a) Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy or, b) Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy, 4) Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma, 5) Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, OR 6) Diagnosis of one of the following previously untreated, advanced stage indications: a) CD-20-positive diffuse large B-cell lymphoma, b) Burkitt lymphoma, c) Burkitt-like lymphoma, or d) mature B-cell acute leukemia. Patient is 6 months of age or older. Used in combination with chemotherapy. Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia. Used in combination with fludarabine and cyclophosphamide. Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV. All indications: Trial and failure or intolerance to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs).
Age Restrictions	N/A

Prescriber Restrictions	NHL, CLL: Prescribed by or in consultation with a hematologist/oncologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist. RA: Prescribed by or in consultation with a rheumatologist. PV: Prescribed by or in consultation with a dermatologist.
Coverage Duration	NHL, CLL, PV: 12 months. WG, MPA: 3 months. RA: 1 month.
Other Criteria	Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab). All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ (S)

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA)(init): Diagnosis (Dx) of moderately to severely active RA. RA,PJIA(init): Minimum (min) duration of a 3-mo(RA)/6-wk(PJIA) trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, (RA only) sulfasalazine. Psoriatic arthritis (PsA)(init): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS)(init): Dx of active AS. Non-radiographic axial spondyloarthritis(NRAS, init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one TNF inhibitors (TNF-I) (eg, certolizumab pegol). AS, NRAS(init): Min duration of a 1-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PJIA, PsA, AS(init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab, etanercept). RA, PJIA, PsA, AS, NRAS(init, reauth): Not used in combo with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine [AZA], cyclosporine [CYC]). Atopic dermatitis(AD)(init): Dx of moderate to severe AD. One of the following: Involvement of at least 10% body surface area (BSA), or SCORing Atopic Dermatitis (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for topical corticosteroids), C/I to one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus, Tacrolimus oint, or Eucrisa. One of the following: 1) TF of a min 12-wk supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent), OR 2) Pt has a C/I, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent. Not used in combo with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC).
Age Restrictions	AD (initial): Patient is 12 years of age or older

Prescriber Restrictions	RA, PJIA, AS, NRAS, GCA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. CD, UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	RA, PJIA, PsA, AS, NRAS, CD, UC, AD, GCA (init): 6 months, (reauth): 12 months.

Other Criteria	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Dx of active PJIA. Crohn's disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative colitis (UC) (init): Dx of moderately to severely active UC. One of the following: greater than 6 stools/day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF-I (eg, adalimumab), OR if treatment is inadvisable (ie, CI) with a TNF-I, pt has had a trial of a systemic therapy approved for CD/UC (eg, risankizumab, ustekinumab). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC). Giant cell arteritis (GCA) (init): Dx of GCA. GCA (reauth): Pt demonstrates positive clinical response to therapy. GCA (init, reauth): Not used in combo with other JAK-I, biologic DMARDs, or potent immunosuppressants (eg, AZA, CYC). RA, PJIA (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (ESR, CRP), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, AZA, CYC). CD/UC (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, ESR, CRP]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, AZA, CYC).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ LQ (S)

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Polyarticular juvenile idiopathic arthritis (PJIA) (init): Diagnosis of active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide. Psoriatic arthritis (PsA) (init): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PJIA, PsA (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). PJIA, PsA (init, reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	PJIA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	PJIA, PsA (init): 6 months, (reauth): 12 months.
Other Criteria	PJIA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RITUXAN (S)

Products Affected

- Rituxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma(NHL): One of the following: 1) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Used as first-line treatment in combination with chemotherapy, 2) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy. Used as monotherapy for maintenance therapy, 3) Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma. One of the following: a) Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy or, b) Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy, 4) Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma, 5) Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, OR 6) Diagnosis of one of the following previously untreated, advanced stage indications: a) CD-20-positive diffuse large B-cell lymphoma, b) Burkitt lymphoma, c) Burkitt-like lymphoma, or d) mature B-cell acute leukemia. Patient is 6 months of age or older. Used in combination with chemotherapy. Trial and failure or intolerance (TF/I) to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs).
Age Restrictions	N/A
Prescriber Restrictions	ITP, CLL, NHL: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist. PV: Prescribed by or in consultation with a dermatologist.

Coverage Duration	All uses except RA, WG, MPA: 12 mos. RA: 1 month. WG, MPA: 3 months only.
Other Criteria	Immune or idiopathic thrombocytopenic purpura (ITP): Diagnosis of ITP. TF/C/I to one of the following: glucocorticoids (e.g., prednisone, methylprednisolone), immune globulins (e.g., IVIG), or splenectomy. Documented platelet count of less than 50x10^9 /L. Chronic Lymphocytic Leukemia (CLL): Diagnosis of CLL. Used in combination with fludarabine and cyclophosphamide. TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV. TF/I to both Ruxience and Truxima. Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab) and TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Wegener's Granulomatosis (WG)/Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RITUXAN HYCELA (S)

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Follicular Lymphoma: Diagnosis of follicular lymphoma. One of the following: 1) Disease is relapsed or refractory OR 2) Patient exhibited complete or partial response to prior treatment with rituximab in combination with chemotherapy OR 3) Disease is non-progressing or stable following prior treatment with first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy OR 4) Both of the following: a) Disease is previously untreated AND b) Medication is used in combination with first-line chemotherapy. Trial and failure or intolerance (TF/I) to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Diffuse Large B-Cell Lymphoma: 1) Diagnosis of diffuse large B-cell lymphoma AND 2) Disease is previously untreated AND 3) Medication is being used in combination with cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy. TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs). Chronic Lymphocytic Leukemia: 1) Diagnosis of chronic lymphocytic leukemia AND 2) Medication is being used in combination with fludarabine and cyclophosphamide (FC) therapy. TF/I to Ruxience (rituximab-pvvr) and Truxima (rituximab-abbs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RIVFLOZA (S)

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary hyperoxaluria type 1 (PH1). Disease has been confirmed by both of the following: a) One of the following: i) Elevated urinary oxalate excretion, ii) Elevated plasma oxalate concentration, or iii) Spot urinary oxalate to creatinine molar ratio greater than normal for age, and b) One of the following: i) Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene, or ii) Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity. Patient has preserved kidney function (e.g., eGFR greater than or equal to 30mL/min/1.73m^2).
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROLVEDON (S)

Products Affected

- Rolvedon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis).
Age Restrictions	N/A
Prescriber Restrictions	FN prophylaxis: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	FN prophylaxis: 3 mo or duration of tx.
Other Criteria	FN prophylaxis: Trial and failure or intolerance to one of the following: Neulasta/Neulasta Onpro OR Udenyca/Udenyca Onbody.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ROMVIMZA (S)

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of tenosynovial giant cell tumor (TGCT). Patient is symptomatic. Surgical resection will potentially cause worsening functional limitation or severe morbidity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROZLYTREK (S)

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer (NSCLC). Presence of ROS1 rearrangement positive tumor(s). Solid Tumors: Diagnosis of solid tumors. Presence of neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). No known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: disease has progressed following previous treatment (e.g., surgery, radiation therapy, or systemic therapy) or disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUBRACA (S)

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Prostate cancer: Diagnosis of castration-resistant prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUCONEST (S)

Products Affected

- Ruconest

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
Age Restrictions	Initial: Patient is 13 years of age or older
Prescriber Restrictions	HAE (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for acute HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUXIENCE (S)

Products Affected

- Ruxience

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma (NHL): One of the following: 1) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Used as first-line treatment in combination with chemotherapy, 2) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy. Used as monotherapy for maintenance therapy, 3) Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma. One of the following: a) Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy or, b) Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy, 4) Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma, 5) Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, OR 6) Diagnosis of one of the following previously untreated, advanced stage indications: a) CD-20-positive diffuse large B-cell lymphoma, b) Burkitt lymphoma, c) Burkitt-like lymphoma, or d) mature B-cell acute leukemia. Patient is 6 months of age or older. Used in combination with chemotherapy. Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia. Used in combination with fludarabine and cyclophosphamide. Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV.
Age Restrictions	N/A

Prescriber Restrictions	NHL, CLL: Prescribed by or in consultation with a hematologist/oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist. PV: Prescribed by or in consultation with a dermatologist.
Coverage Duration	NHL, CLL, PV: 12 months. WG, MPA: 3 months. RA: 1 month.
Other Criteria	Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab). Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYBELSUS (S)

Products Affected

- Rybelsus TABS 14MG, 3MG, 7MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYBREVANT (S)

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYBREVANT FASPRO (S)

Products Affected

- Rybrevant Faspro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYDAPT (S)

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYSTIGGO (S)

Products Affected

- Rystiggo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized myasthenia gravis (gMG). One of the following: Patient is anti-acetylcholine receptor (AChR) antibody positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) Both of the following: a) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and b) TF/C/I to one of the following: chronic plasmapheresis or plasma exchange (PE), intravenous immunoglobulin (IVIG), or rituximab.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYTELO (S)

Products Affected

- Rytelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of myelodysplastic syndrome. Disease is low to intermediate-1 risk. All of the following: a) Hemoglobin less than 10 g/dL, b) Baseline absolute neutrophil count of 1.5 x 10^9/L or greater, and c) Baseline platelet count of 75 x 10^9/L or greater. Both of the following: a) Patient does not have a confirmed mutation with deletion 5q [del(5q)] and b) Patient has not received prior treatment with Revlimid (lenalidomide) or hypomethylating agents (e.g., azacitidine, decitabine). Patient requires 4 or more red blood cell units over 8 weeks. One of the following: a) Previous treatment with an erythropoiesis stimulating agent shows no response, b) Previous treatment with an erythropoiesis stimulating agent shows loss of response, or c) Patient is ineligible for treatment with an erythropoiesis stimulating agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYZNEUTA (S)

Products Affected

- Ryzneuta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ARS: 1 mo. FN prophylaxis: 3 mo or duration of tx.
Other Criteria	FN prophylaxis: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta AND Udenyca.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SABRIL (S)

Products Affected

- Sabril
- Vigabatrin
- Vigadrone
- Vigpoder

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	IS: 1 month to 2 years of age. CPS: 2 years or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SAMSCA (S)

Products Affected

- Samsca
- Tolvaptan TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of significant hyponatremia (euvolemic or hypervolemic). Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SANDOSTATIN (S)

Products Affected

- Octreotide Acetate INJ 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML, 50MCG/ML
- Sandostatin INJ 100MCG/ML, 500MCG/ML, 50MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection and/or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Trial and failure, contraindication or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy. Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SANDOSTATIN LAR (S)

Products Affected

- Octreotide Acetate INJ 10MG, 20MG, 30MG
- Sandostatin Lar Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection and/or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Trial and failure, contraindication or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea. Patient had a trial of short-acting octreotide and responded to and tolerated therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy. Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SAPHNELO (S)

Products Affected

- Saphnelo INJ 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic lupus erythematosus (SLE) (initial): Diagnosis of moderate to severe SLE. Currently receiving standard of care treatment for SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]).
Age Restrictions	N/A
Prescriber Restrictions	SLE (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	SLE (initial, reauth): 6 months.
Other Criteria	SLE (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SAPHNELO SC (S)

Products Affected

- Saphnelo INJ 120MG/0.8ML
- Saphnelo Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic lupus erythematosus (SLE) (initial): Diagnosis of moderate to severe SLE. Currently receiving standard of care treatment for SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]).
Age Restrictions	N/A
Prescriber Restrictions	SLE (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	SLE (initial, reauth): 6 months.
Other Criteria	SLE (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SARCLISA (S)

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SCEMBLIX (S)

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Disease is Philadelphia chromosome-positive (Ph+). Disease is in chronic phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SCIG (S)

Products Affected

- Cutaquig
- Cuvitru
- Hizentra
- Hyqvia
- Xembify

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Medication is being used subcutaneously. Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) OR one of the following FDA-approved or literature supported diagnoses: 1) Common variable immunodeficiency (CVID), OR 2) Congenital agammaglobulinemia (X-linked or autosomal recessive), OR 3) Severe combined immunodeficiencies (SCID), OR 4) Wiskott-Aldrich syndrome, OR 5) Other primary immunodeficiency with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine).
Age Restrictions	Primary immunodeficiency (Hyqvia only) (initial): Patient is 2 years of age or older.
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on SCIG therapy (e.g., immunologist, hematologist, neurologist).
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. All uses (reauth): Patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SEPHIENCE (S)

Products Affected

- Sephience

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of phenylketonuria (PKU). Patient will have Phe blood levels measured within 2 weeks of therapy (new starts to therapy only) and periodically for up to 3 months of therapy to determine response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SEROSTIM (S)

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m2, or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m2, or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m2. Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes).
Age Restrictions	N/A
Prescriber Restrictions	Initial/Reauth: Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	HIV wasting (reauth): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI. Patient is currently receiving treatment with antiretrovirals.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIGNIFOR (S)

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's disease (initial): Diagnosis of Cushing’s disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Cushing's disease (initial, reauth): 12 months
Other Criteria	Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIGNIFOR LAR (S)

Products Affected

- Signifor Lar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: a) Inadequate response to surgery or b) Patient is not a candidate for surgery. Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy (e.g., patient's growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved). Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIKLOS (S)

Products Affected

- Siklos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of sickle cell anemia. Patient has moderate to severe painful crises.
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SILIQ (S)

Products Affected

- Siliq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (initial): Diagnosis of moderate-to-severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plaque psoriasis (initial): 6 months. Plaque psoriasis (reauth): 12 months.
Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIMPONI (S)

Products Affected

- Simponi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq/Rinvoq LQ (upadacitinib), Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to two of the following: Cosentyx SC, Enbrel, one formulary adalimumab product, Rinvoq, or Xeljanz/Xeljanz XR, OR for continuation of prior therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Either TF/C/I to two of the following: one formulary adalimumab product, Skyrizi, Tremfya, one formulary ustekinumab product, Rinvoq, Xeljanz/Xeljanz XR, OR b) for continuation of prior therapy.
Age Restrictions	N/A

Prescriber Restrictions	RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (Initial): 12 weeks, (Reauth): 12 months. RA, AS, PsA (Initial): 6 months, (Reauth): 12 months
Other Criteria	RA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIMPONI ARIA (S)

Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), or b) attestation demonstrating a trial may be inappropriate, OR c) For continuation of prior therapy. Polyarticular Juvenile Idiopathic Arthritis (PJIA): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq/LQ (upadacitinib), Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to two of the following: Cosentyx SC (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration	All Indications (Initial): 6 months, (Reauth): 12 months.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SKYCLARYS (S)

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Friedreich's ataxia confirmed via genetic testing demonstrating mutation in the FXN gene. Patient has a B-type natriuretic peptide value less than or equal to 200 pg/mL.
Age Restrictions	Initial: Patient is 16 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Physiatrist (Physical Medicine and Rehabilitation Specialist).
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYRIZI (S)

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 55MG/0.37ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, OR palmoplantar (ie, palms, soles), facial, scalp, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (initial): 6 months, (reauth): 12 months

Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SKYRIZI IV (S)

Products Affected

- Skyrizi INJ 600MG/10ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Will be administered as an intravenous induction dose. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Will be administered as an intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	UC, CD: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC, CD: 3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYTROFA (S)

Products Affected

- Skytrofa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pediatric Growth Hormone Deficiency (PGHD) (initial): Both of the following: 1) Diagnosis of PGHD as confirmed by one of the following: a) Height is documented by one of the following (utilizing age and gender growth charts related to height): i) height is greater than 2.0 standard deviations (SD) below midparental height OR ii) height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender), b) Growth velocity is greater than 2 SD below mean for age and gender, or c) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (eg, delayed greater than 2 years compared with chronological age), AND 2) Patient demonstrates one of the following: a) Patient is male with bone age less than 16 years, OR b) Patient is female with bone age less than 14 years. Patient weight is 11.5 kg or greater. Trial and failure or intolerance to Genotropin. Isolated Growth Hormone Deficiency in Adults (IGHDA) (initial): Documentation of GHD as demonstrated by both of the following: A) Patient has undergone two of the following GH stimulation tests: 1) insulin tolerance test [ITT], 2) glucagon, or 3) macimorelin, AND B) Two of the corresponding peak GH values: 1) ITT less than or equal to 5 mcg/L, 2) glucagon less than or equal to 3 mcg/L, 3) macimorelin less than or equal to 2.8 ng/mL 30, 45, 60, 90 mins after administration. Trial and failure or intolerance to Genotropin.
Age Restrictions	PGHD (initial): 1 year of age or older.
Prescriber Restrictions	PGHD, AGHD, IGHDA (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	PGHD, AGHD, IGHDA (initial, reauth): 12 months.

Other Criteria	PGHD (reauth): Both of the following: 1) Expected adult height not attained AND 2) Documentation of expected adult height goal. Adult Growth Hormone Deficiency (AGHD) (initial): Diagnosis of AGHD as a result of one of the following: A) Clinical records supporting diagnosis of childhood-onset GHD, OR B) Adult-onset GHD with clinical records documenting hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage). One of the following: A) Both of the following: 1) Patient has undergone one of the following GH stimulation tests to confirm AGHD: a) ITT, b) glucagon, or c) macimorelin, AND 2) One of the following peak GH values: a) ITT less than or equal to 5 mcg/L, b) glucagon less than or equal to 3 mcg/L, c) macimorelin less than or equal to 2.8 ng/mL 30, 45, 60 and 90 mins after administration, OR B) Both of the following: 1) Documented deficiency of 3 anterior pituitary hormones: a) prolactin, b) adrenocorticotropic hormone (ACTH), c) thyroid stimulating hormone (TSH), d) follicle-stimulating hormone/luteinizing hormone (FSH/LH), AND 2) IGF-1/somatomedin-C below age and gender adjusted normal range as provided by the physician's lab. Trial and failure or intolerance to Genotropin. AGHD, IGHDA (reauth): Evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/somatomedin-C level.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOFDRA (S)

Products Affected

- Sofdra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary axillary hyperhidrosis. Provider attests other causes of axillary hyperhidrosis have been ruled out (e.g., menopause, medication).
Age Restrictions	Initial: Patient is 9 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 6 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOGROYA (S)

Products Affected

- Sogroya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pediatric Growth Hormone Deficiency (PGHD) (initial): Diagnosis (dx) of PGHD as confirmed by one of the following: A) Height (ht) is documented by one of the following (utilizing age and gender growth charts related to ht): 1) ht is greater than 2.0 standard deviations (SD) below midparental ht, or 2) ht is greater than 2.25 SD below population (pop) mean (below the 1.2 percentile for age and gender), B) Growth velocity is greater than 2 SD below mean for age and gender, or C) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age). Isolated Growth Hormone Deficiency in Adults (IGHDA) (initial): Documentation (doc) of GHD as demonstrated by both of the following: A) Patient has undergone two of the following GH stim tests: 1) insulin tolerance test [ITT], 2) glucagon, or 3) macimorelin, AND B) Two of the corresponding peak GH values: 1) ITT less than or equal to 5 mcg/L, 2) glucagon less than or equal to 3mcg/L, 3) macimorelin less than or equal to 2.8 ng/mL 30, 45, 60, 90 mins after administration. Growth Failure in Children Small for Gestational Age (GFSGA) (initial): Dx of SGA based on catchup growth failure in 1st 24mo of life using 0-36mo growth chart confirmed by birth weight or length below 3rd percentile for gestational age (more than 2SD below pop mean). Ht remains at or below 3rd percentile (more than 2SD below pop mean). Noonan Syndrome (NS) (initial): Dx of pediatric growth failure assoc w/ NS. Ht below 5th percentile on growth charts for age and gender. Idiopathic Short Stature (ISS) (initial): Dx of ISS. Diagnostic eval excluded other causes assoc w/short stature (eg, GHD, chronic renal insufficiency). Doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult ht in the normal range.
Age Restrictions	PGHD, NS, ISS, GFSGA (initial): Patient is 2.5 years of age or older.

Prescriber Restrictions	PGHD, AGHD, IGHDA, NS, ISS, GFSGA (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	PGHD, AGHD, IGHDA, NS, ISS, GFSGA (initial, reauth): 12 months.
Other Criteria	PGHD, NS, ISS (initial): Doc of one of the following: A) Patient is male with bone age less than 16 years, or B) Patient is female with bone age less than 14 years. PGHD, NS, ISS, GFSGA (reauth): Both of the following: A) Expected adult height not attained, AND B) Documentation of expected adult height goal. Adult Growth Hormone Deficiency (AGHD) (initial): Diagnosis of AGHD as a result of one of the following: A) Clinical records supporting diagnosis of childhood-onset GHD, or B) Adult-onset GHD with clinical records documenting hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage). One of the following: A) Both of the following: 1) Patient has undergone one of the following GH stim tests to confirm AGHD: a) ITT, b) glucagon, or c) macimorelin, AND 2) One of the following peak GH values: a) ITT less than or equal to 5mcg/L, b) glucagon less than or equal to 3 mcg/L, c) macimorelin less than or equal to 2.8 ng/mL 30, 45, 60 and 90 mins after administration, OR B) Both of the following: 1) Documented deficiency of 3 anterior pituitary hormones: a) prolactin, b) adrenocorticotropic hormone (ACTH), c) thyroid stimulating hormone (TSH), d) follicle-stimulating hormone/luteinizing hormone (FSH/LH), AND 2) IGF-1/somatomedin-C below age and gender adjusted normal range as provided by the physician's lab. PGHD, AGHD, IGHDA, ISS, GFSGA (initial): Trial and failure or intolerance to Genotropin. AGHD, IGHDA (reauth): Evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/somatomedin-C level.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOHONOS (S)

Products Affected

- Sohonos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of fibrodysplasia ossificans progressiva (FOP). Molecular genetic testing confirms mutation in the ACVR1 gene. One of the following: A) Both of the following: 1) Patient is female, and 2) Patient is 8 years of age or older, OR B) Both of the following: 1) Patient is male, and 2) Patient is 10 years of age or older.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a geneticist, orthopedic physician, rheumatologist, or endocrinologist.
Coverage Duration	Initial: 12 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOLIRIS (S)

Products Affected

- Soliris

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (initial): Diagnosis of PNH. Trial and failure, contraindication, or intolerance (TF/C/I) to Ultomiris (ravulizumab). Atypical Hemolytic Uremic Syndrome (aHUS) (initial): Diagnosis of aHUS. TF/C/I to Ultomiris (ravulizumab). Generalized Myasthenia Gravis (gMG) (initial): Diagnosis of gMG. Patient is anti-acetylcholine (AChR) antibody positive. TF/C/I to one of the following: immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), chronic plasmapheresis/plasma exchange (PE), or intravenous immunoglobulin (IVIG). Trial and failure, contraindication (e.g., age), or intolerance to Ultomiris (ravulizumab). Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive. TF/C/I to Ultomiris (ravulizumab).
Age Restrictions	N/A
Prescriber Restrictions	PNH (initial): Prescribed by or in consultation with a hematologist/oncologist. aHUS (initial): Prescribed by or in consultation with a hematologist or nephrologist. NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist. gMG (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	All uses (initial, reauth): 12 months.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOMATULINE DEPOT (S)

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly: Diagnosis of acromegaly. One of the following: A) Inadequate response to one of the following: surgery or radiotherapy, OR B) Not a candidate for one of the following: surgery or radiotherapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (120mg/0.5mL strength only): Diagnosis of GEP-NETs. Disease is one of the following: (a) unresectable, locally advanced or (b) metastatic. Carcinoid syndrome (120mg/0.5mL strength only): Diagnosis of carcinoid syndrome. Used to reduce the frequency of short-acting somatostatin analog rescue therapy.
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist. Carcinoid syndrome (initial): Prescribed by or in consultation with an endocrinologist or oncologist.
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOMAVERT (S)

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) failure to one of the following: surgery, radiation therapy, or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) or 2) not a candidate for one of the following: surgery, radiation therapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy. One of the following: 1) inadequate response, contraindication, or intolerance to a somatostatin analog (e.g., octreotide, lanreotide) or 2) clinical rationale provided for preferred treatment with pegvisomant (e.g., comorbid diabetes mellitus is present with acromegaly).
Age Restrictions	N/A
Prescriber Restrictions	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial and reauth: 12 months
Other Criteria	Acromegaly (reauth): Patient has experienced a positive clinical response to therapy (biochemical control, decrease or normalization of IGF-1 levels).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SOVALDI (S)

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. All GT1 and GT4: 1) Intolerance or contraindication (eg, safety concerns, not indicated for patient's age/weight) to both of the following: a) sofosbuvir/velpatasvir and b) Mavyret OR 2) For continuation of prior therapy. For GT2 or GT3 patients using sofosbuvir plus ribavirin: Intolerance or contraindication (eg, safety concerns, not indicated for patient's age/weight) to a) sofosbuvir/velpatasvir AND Mavyret OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	12 to 48 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SPEVIGO (S)

Products Affected

- Spevigo INJ 150MG/ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized pustular psoriasis (GPP) as defined by primary, sterile, macroscopically visible pustules (excluding cases where pustulation is restricted to psoriatic plaques). Subcutaneous formulation will not be used to treat GPP flare. Patient weighs at least 40kg.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPEVIGO IV (S)

Products Affected

- Spevigo INJ 450MG/7.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of generalized pustular psoriasis (GPP). Patient has a moderate to severe GPP flare based on one of the following: a) presence of fresh pustules (new appearance or worsening of pustules), b) at least 5% of body surface area (BSA) covered with erythema and the presence of pustules, c) a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate), or d) GPPPGA pustulation sub score of at least 2 (mild). Patient weighs at least 40kg. Patient has not already received two infusions of Spevigo for a single flare.
Age Restrictions	Patient is 12 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist.
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPINRAZA (S)

Products Affected

- Spinraza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) Type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on invasive ventilation or tracheostomy. Patient is not dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam (HINE) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Upper Limb Module (ULM) Test (Non ambulatory), or Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND). Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures. Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Evrysdi). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).
Age Restrictions	N/A
Prescriber Restrictions	SMA (initial, reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

Coverage Duration	Initial: 3 months. Reauth: 6 months.
Other Criteria	SMA (reauth): Patient demonstrates positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from one of the following exams: A) One of the following HINE-2 milestones: 1) Improvement or maintenance of a previous improvement of at least a 2 point (or maximal score) increase in ability to kick OR 2) Improvement or maintenance of a previous improvement of at least a 1 point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp OR 3) Patient exhibited improvement, or maintenance of a previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement) OR 4) Patient has achieved and maintained any new motor milestones from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk) OR B) One of the following HFMSE milestones: 1) Improvement or maintenance of a previous improvement of at least a 3 point increase in score from pretreatment baseline OR 2) Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk) OR C) One of the following ULM test milestones: 1) Improvement or maintenance of a previous improvement of at least a 2 point increase in score from pretreatment baseline OR 2) Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk) OR D) One of the following CHOP INTEND milestones: 1) Improvement or maintenance of a previous improvement of at least a 4 point increase in score from pretreatment baseline OR 2) Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk). Patient continues to not be dependent on invasive ventilation or tracheostomy. Patient continues to not be dependent on use of non-invasive ventilation beyond use for naps and nighttime sleep. Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures. Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Evrysdi). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRAVATO (S)

Products Affected

- Spravato 56mg Dose
- Spravato 84mg Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Both of the following: 1) Diagnosis of major depressive disorder and 2) Patient has not experienced a clinical meaningful improvement after treatment with at least two antidepressants from different classes for an adequate duration (at least 4 weeks each) in the current depressive episode OR B) All of the following: 1) Diagnosis of major depressive disorder, 2) Patient has both of the following: a) depressive symptoms and b) acute suicidal ideation or behavior, and 3) Used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRYCEL (S)

Products Affected

- Dasatinib
- Phyrago
- Sprycel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Philadelphia chromosome positive (Ph+)/BCR ABL chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML. Ph+/BCR ABL acute lymphoblastic leukemia (ALL): Diagnosis of Ph+/BCR ABL ALL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STELARA (IV) (S)

Products Affected

- Stelara INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One time
Other Criteria	Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STELARA (S)

Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose. All indications (initial): Trial of either Steqeyma or Wezlana.
Age Restrictions	Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older.
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (Initial): 6 months. All uses (reauth): 12 months

Other Criteria	Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD (Reauth), UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

STEQEYMA (S)

Products Affected

- Steqeyma INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose.
Age Restrictions	Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older.
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): 12 months.

Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

STEQEYMA IV (S)

Products Affected

- Steqeyma INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One time
Other Criteria	Will be administered as an intravenous induction dose. Induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STIMUFEND (S)

Products Affected

- Stimufend

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta AND Udenyca.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

STIVARGA (S)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Gastrointestinal stromal tumor (GIST): Diagnosis of locally advanced, unresectable or metastatic GIST. Hepatocellular Carcinoma (HCC): Diagnosis of HCC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STRENSIQ (S)

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypophosphatasia (initial): Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia. One of the following: 1) Both of the following: a) Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range AND b) Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level]) OR 2) Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing. For patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg.
Age Restrictions	N/A
Prescriber Restrictions	Hypophosphatasia (initial, reauth): Prescribed by a specialist experienced in the treatment of inborn errors of metabolism or an endocrinologist
Coverage Duration	Hypophosphatasia (initial): 6 months, (reauth): 12 months
Other Criteria	Hypophosphatasia (reauth): Patient demonstrates positive clinical response to therapy. For patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUCRAID (S)

Products Affected

- Sucraid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Congenital Sucrase-Isomaltase Deficiency (CSID) (initial): Diagnosis of sucrase deficiency (which is part of congenital sucrose-isomaltase deficiency [CSID]).
Age Restrictions	CSID (initial): Patient is 5 months of age or older.
Prescriber Restrictions	CSID (initial): Prescribed by or in consultation with a gastroenterologist or geneticist.
Coverage Duration	CSID (initial, reauth): 12 months.
Other Criteria	CSID (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUNOSI (S)

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy (initial): Diagnosis (Dx) of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Obstructive Sleep Apnea (OSA) (initial): Dx of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND one of the following signs/symptoms are present: daytime sleepiness, nonrestorative sleep, fatigue, insomnia, waking up with breath holding/gasping/choking, habitual snoring noted by a bed partner or other observer, or observed apnea. All uses (initial): Trial and failure, contraindication or intolerance to both generic modafinil and generic armodafinil.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Narcolepsy, OSA (initial, reauth): 12 months.
Other Criteria	Narcolepsy (reauth): Patient demonstrates positive clinical response to therapy. OSA (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SUPPRELIN LA (S)

Products Affected

- Supprelin La

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUSVIMO (S)

Products Affected

- Susvimo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neovascular (wet) age-related macular degeneration (nAMD) and Diabetic Macular Edema (DME) (Initial): One of the following diagnoses: a) Neovascular (wet) age-related macular degeneration (nAMD) or b) Diabetic macular edema (DME). Trial and positive response to at least 2 intravitreal injections of ONE of the following: a) Compounded bevacizumab prepared by a 503(B) Outsourcing Facility, or b) Lucentis (ranibizumab). Diabetic Retinopathy (DR) (Initial): Diagnosis of diabetic retinopathy (DR). Patient has previously responded to at least two intravitreal injections of a Vascular Endothelial Growth Factor (VEGF) inhibitor medication (e.g., Lucentis).
Age Restrictions	N/A
Prescriber Restrictions	Initial (nAMD, DME, DR): Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	Initial, Reauth (nAMD, DME, DR): 12 months.
Other Criteria	Reauth (nAMD, DME, DR): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SUTENT (S)

Products Affected

- Sunitinib Malate
- Sutent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on, or contraindication or intolerance to Gleevec (imatinib). Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease. Adjuvant treatment of renal cell carcinoma: Diagnosis of renal cell carcinoma (RCC). Used as adjuvant therapy. Patient is at high risk of recurrent RCC following nephrectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYFOVRE (S)

Products Affected

- Syfovre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) as confirmed by one of the following: 1) Fundus photography (e.g., fundus autofluorescence [FAF]), 2) Optical coherence tomography (OCT), or 3) Fluorescein angiography.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYLVANT (S)

Products Affected

- Sylvant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multicentric Castleman's disease (MCD) (Initial): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MCD (initial, reauth): 6 months
Other Criteria	MCD (reauth): Patient demonstrates positive clinical response to therapy. Patient is HIV negative and HHV-8 negative.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYMDEKO (S)

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cystic fibrosis. One of the following: 1) Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR 2) Patient has at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	Initial: Patient is 6 years of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SYMLIN (S)

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes. Patient has failed to achieve desired glucose control despite optimal insulin therapy. Patient is taking concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline. Patient is receiving concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYNDROS (S)

Products Affected

- Dronabinol SOLN
- Syndros

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance (TF/C/I) to a 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). TF/C/I to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 3 months.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving chemotherapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYPRINE (S)

Products Affected

- Syprine
- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TABRECTA (S)

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TADLIQ (S)

Products Affected

- Tadliq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFAMIDIS (S)

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Presence of a transthyretin (TTR) mutation (e.g., V122I) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) Both of the following: i) echocardiogram or cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis, and ii) absence of light-chain amyloidosis. Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal).
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): 12 months
Other Criteria	ATTR-CM (reauth): Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFINLAR (S)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR both of the following: cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and medication is used in combination with Mekinist (trametinib). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic anaplastic thyroid cancer. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Mekinist (trametinib) .
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib). Low-grade Glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAGRISSO (S)

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): One of the following: A) All of the following: Diagnosis of metastatic NSCLC. One of the following: 1) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), OR 2) Both of the following: a) Patient has known active EGFR T790M mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and b) Patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), or Vizimpro (dacomitinib). OR B) All of the following: Diagnosis of NSCLC. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: 1) Patient is receiving as adjuvant therapy, and 2) Patient has had a complete surgical resection of the primary NSCLC tumor. OR C) All of the following: Diagnosis of NSCLC. Disease is locally advanced. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. FDA-approved test or a test performed at a facility approved by CLIA. Used in combination with both of the following: a) Pemetrexed, and b) Platinum-based chemotherapy (e.g., cisplatin, carboplatin). Or D) Refer to Other Criteria element for additional indication and criteria.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	12 months
Other Criteria	NSCLC cont: OR D) All of the following: Diagnosis of NSCLC. Disease is Locally advanced, Unresectable (Stage III). Presence of known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy. All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAKHZYRO (S)

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of hereditary angioedema (HAE) attacks (initial): Diagnosis of HAE. One of the following: 1) Diagnosis has been confirmed by both of the following: a) C4 level below the lower limit of normal, and b) C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: i) C1-INH antigenic level below the lower limit of normal OR ii) C1-INH functional level below the lower limit of normal, OR 2) Diagnosis has been confirmed by both of the following: a) Both of the following: i) Normal C4 level AND ii) Normal C1-INH levels (HAE-nl-C1INH previously referred to as HAE Type III), and b) One of the following: i) Presence of a factor XII, plasminogen, angiopoietin-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6 gene mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR ii) Patient has a confirmed family history of recurrent angioedema. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
Age Restrictions	HAE (prophylaxis) (initial): Patient is 2 years of age or older
Prescriber Restrictions	HAE (prophylaxis) (initial): Prescribed by or in consultation with an immunologist or an allergist
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with other approved treatments for prophylaxis against HAE attacks.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TALTZ (S)

Products Affected

- Taltz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure, contraindication (eg, safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Tremfya (guselkumab), one formulary ustekinumab product, OR for continuation of prior therapy. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx SC, Enbrel, one formulary adalimumab product, Orencia (abatacept), Otezla, Skyrizi, Sotyktu, Tremfya, one formulary ustekinumab product, Rinvoq/LQ (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy. Ankylosing spondylitis (AS) (initial): Diagnosis of active AS. One of the following: a) TF/C/I to two of the following: Cosentyx SC, Enbrel, one formulary adalimumab product, Rinvoq, or Xeljanz/XR, OR b) for continuation of prior therapy. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) One of the following: a) TF/C/I to Cosentyx SC and Rinvoq, OR b) for continuation of prior therapy.
Age Restrictions	N/A

Prescriber Restrictions	Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AS, nr-axSpA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Initial: 6 months, reauth: 12 months
Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TALVEY (S)

Products Affected

- Talvey

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TALZENNA (S)

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer (mCRPC). Disease is homologous recombination repair (HRR) gene-mutated. Taken in combination with Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TARCEVA (S)

Products Affected

- Erlotinib Hydrochloride TABS
- Tarceva TABS 100MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND erlotinib will be used in combination with gemcitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TARGRETIN (S)

Products Affected

- Bexarotene
- Targretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, brentuximab vedotin, methotrexate]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TARPEYO (S)

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool). Used to reduce the loss of kidney function.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	9 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TASCENSO (S)

Products Affected

- Tascenso Odt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
Age Restrictions	MS (initial): Patient is 10 years of age or older.
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TASIGNA (S)

Products Affected

- Nilotinib Hydrochloride
- Tasigna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAVALISSE (S)

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic ITP or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., dexamethasone, prednisone), immune globulins (e.g., Gammaplex, Gammagard S/D), or splenectomy.
Age Restrictions	N/A
Prescriber Restrictions	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	ITP (initial, reauth): 12 months
Other Criteria	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAVNEOS (S)

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of one of the following types of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: a) Granulomatosis with polyangiitis (GPA) OR b) Microscopic polyangiitis (MPA). Diagnosis is confirmed by one of the following: a) ANCA test positive for proteinase 3 (PR3) antigen, b) ANCA test positive for myeloperoxidase (MPO) antigen, OR c) Tissue biopsy. Patient is receiving concurrent immunosuppressant therapy with one of the following: a) cyclophosphamide OR b) rituximab. One of the following: a) Patient is concurrently on glucocorticoids (e.g., prednisone) OR b) History of contraindication or intolerance to glucocorticoids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with one of the following, with shared decision-making regarding treatment risks: 1) nephrologist, 2) pulmonologist, or 3) rheumatologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient does not show evidence of progressive disease while on therapy. Patient is receiving concurrent immunosuppressant therapy (e.g., azathioprine, cyclophosphamide, methotrexate, rituximab).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAZVERIK (S)

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelioid sarcoma: Diagnosis of epithelioid sarcoma. Disease is one of the following: metastatic or locally advanced. Patient is not eligible for complete resection. Follicular lymphoma: Diagnosis of follicular lymphoma. Disease is one of the following: relapsed or refractory.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TECENTRIQ (S)

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TECENTRIQ HYBREZA (S)

Products Affected

- Tecentriq Hybreza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TECFIDERA (S)

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0
- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TECVAYLI (S)

Products Affected

- Tecvayli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEGSEDI (S)

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Presence of a transthyretin (TTR) mutation (e.g., V30M) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy). Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Age Restrictions	N/A
Prescriber Restrictions	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	hATTR amyloidosis (initial, reauth): 12 months.
Other Criteria	hATTR amyloidosis (reauth): Patient demonstrates postive clinical response to therapy. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEPEZZA (S)

Products Affected

- Tepezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid eye disease (TED): Diagnosis of TED. Trial and failure (minimum 4 weeks), contraindication or intolerance to at least one oral or IV glucocorticosteroid (e.g., prednisone, methylprednisolone). Treatment with Tepezza has not exceeded a total of 8 infusions.
Age Restrictions	N/A
Prescriber Restrictions	TED: Prescribed by or in consultation with an endocrinologist or ophthalmologist.
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TEPMETKO (S)

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TERIPARATIDE (S)

Products Affected

- Bonsity
- Forteo INJ 560MCG/2.24ML
- Teriparatide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis or osteopenia or men with primary or hypogonadal osteoporosis or osteopenia (initial): Diagnosis of one of the following: a) postmenopausal osteoporosis or osteopenia or b) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, or Set III) History of fragility fracture (e.g., hip or spine), regardless of BMD. Glucocorticoid-Induced Osteoporosis: See Other Criteria section.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial): 24 months. All uses (reauth): 12 months.

Other Criteria	Glucocorticoid-Induced Osteoporosis (initial): Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months. One of the following: 1) BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site), or 2) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, 3) History of one of the following fractures resulting from minimal trauma: vertebral compression fx, fx of the hip, fx of the distal radius, fx of the pelvis, or fx of the proximal humerus, or 4) One of the following: a) glucocorticoid dosing of at least 30 mg per day, or b) cumulative glucocorticoid dosing of at least 5 grams per year. TF/C/I to one bisphosphonate (e.g., alendronate). All uses (initial, reauth): One of the following: 1) Treatment duration of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient's lifetime, or 2) Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)].
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TESTOSTERONE (S)

Products Affected

- Androgel Pump GEL 20.25MG/ACT
- Depo-testosterone INJ 100MG/ML, 200MG/ML
- Fortesta
- Natesto
- Testim GEL 50MG/5GM
- Testosterone GEL 10MG/ACT, 20.25MG/1.25GM, 25MG/2.5GM, 40.5MG/2.5GM, 50MG/5GM
- Testosterone SOLN
- Testosterone Cypionate INJ 100MG/ML, 200MG/ML
- Testosterone Pump GEL 12.5MG/ACT, 20.25MG/ACT
- Testosterone Topical Solution
- Vogelxo
- Vogelxo Pump

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	Testosterone cypionate only: HG (init): 12 years of age or older. All other testosterone: HG (init): Patient is 18 years of age or older.

Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TESTOSTERONE ENANTHATE (S)

Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GD: 12 mo. DP: 6 mo.

Other Criteria	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEVIMBRA (S)

Products Affected

- Tevimbra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Esophageal Squamous Cell Carcinoma: Diagnosis of esophageal squamous cell carcinoma. Disease is unresectable or metastatic. One of the following: 1) Both of the following: a) Patient has received prior systemic chemotherapy and b) Patient has not previously been treated with a PD-(L)1 inhibitor (e.g., Keytruda, Opdivo) OR 2) Used in combination with platinum-containing chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin). Gastric or Gastroesophageal Junction Adenocarcinoma: Diagnosis of gastric or gastroesophageal junction adenocarcinoma. Disease is unresectable or metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Tumor(s) express PD-L1 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with platinum (e.g., carboplatin, cisplatin, oxaliplatin) and fluoropyrimidine (e.g., fluorouracil)-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEZSPIRE (S)

Products Affected

- Tezspire

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (Initial): Diagnosis of severe asthma. Patient has a history of one of the following within the past 12 months: 1) Two or more asthma exacerbations requiring systemic corticosteroid (e.g., prednisone) treatment OR 2) Prior asthma-related hospitalization. Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (i.e., greater than 500 mcg fluticasone propionate equivalent/day) and ii) Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product (e.g., Wixela Inhub [fluticasone propionate 500mcg/salmeterol 50mcg], budesonide 160mcg/formoterol 4.5mcg, Breo Ellipta [fluticasone 200mcg/vilanterol 25mcg]). One of the following: 1) Medication will not be used to treat eosinophilic asthma OR 2) Both of the following: a) Medication will be used to treat eosinophilic asthma AND b) Trial and failure, contraindication, or intolerance to one of the following: Nucala (mepolizumab), Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab). One of the following: 1) Medication will not be used to treat oral corticosteroid-dependent asthma OR 2) Both of the following: a) Medication will be used to treat oral corticosteroid-dependent asthma AND b) Trial and failure, contraindication, or intolerance to Dupixent (dupilumab). One of the following: 1) Medication will not be used to treat persistent allergic asthma OR 2) Both of the following: a) Medication will be used to treat persistent allergic asthma AND b) Trial and failure, contraindication, or intolerance to Xolair (omalizumab).
Age Restrictions	CRSwNP (Initial): Patient is 12 years of age or older.

Prescriber Restrictions	Asthma (Initial): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (Initial, Reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist.
Coverage Duration	Asthma (Initial): 6 months. (Reauth): 12 months. CRSwNP (Initial, Reauth): 12 months.
Other Criteria	Asthma (Reauth): Patient demonstrates positive clinical response to therapy. Chronic rhinosinusitis with nasal polyps (CRSwNP) (Initial): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. CRSwNP (Reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

THALOMID (S)

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

THYROGEN (S)

Products Affected

- Thyrogen INJ 0.9MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient requires Blood Tg testing or Radioiodine ablation of remnant thyroid tissue after a thyroidectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TIBSOVO (S)

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Newly-Diagnosed AML: Diagnosis of newly-diagnosed AML. One of the following: 1) patient is greater than or equal to 75 years old OR 2) patient has comorbidities that preclude use of intensive induction chemotherapy. Locally Advanced or Metastatic Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is locally advanced or metastatic. Patient has been previously treated. Relapsed or Refractory Myelodysplastic Syndromes: Diagnosis of myelodysplastic syndromes (MDS). Disease is relapsed or refractory. All indications: Patient has an isocitrate dehydrogenase-1 (IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TIGLUTIK (S)

Products Affected

- Tiglutik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Diagnosis of ALS. Trial and failure or intolerance to generic riluzole tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TIVDAK (S)

Products Affected

- Tivdak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TLANDO (S)

Products Affected

- Tlando

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (init): Trial and failure or intolerance to generic testosterone gel. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOLSURA (S)

Products Affected

- Tolsura

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Blastomycosis, Histoplasmosis, or Aspergillosis. Trial and failure or intolerance to generic itraconazole capsules.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TONMYA (S)

Products Affected

- Tonmya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient. Used to treat fibromyalgia related symptoms (e.g., difficulty sleeping).
Age Restrictions	PA applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOPICAL RETINOID (S)

Products Affected

- Atralin
- Retin-a CREA
- Retin-a GEL
- Retin-a Micro
- Retin-a Micro Pump
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump
- Tretinoin Microsphere Pump

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TORPENZ (S)

Products Affected

- Torpenz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast Cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRACLEER (S)

Products Affected

- Bosentan
- Tracleer

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRAZIMERA (S)

Products Affected

- Trazimera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRELSTAR (S)

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TREMFYA INTRAVENOUS (S)

Products Affected

- Tremfya INJ 200MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, C-reactive protein [CRP]), OR CD Activity Index (CDAI) greater than 220. Will be administered as an intravenous induction dose. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, erythrocyte sedimentation rate [ESR], CRP), OR dependent on, or refractory to, corticosteroids. Will be administered as an intravenous induction dose.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC: Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC: 3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TREMFYA SC (S)

Products Affected

- Tremfya INJ 100MG/ML, 200MG/2ML
- Tremfya Induction Pack For Crohns Disease/ulcerative Colitis
- Tremfya Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, OR palmoplantar (ie, palms, soles), facial, scalp, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (initial): Diagnosis of moderately to severely active CD. One of the following: a) Will be used as a maintenance dose following the intravenous induction doses, OR b) Both of the following: 1) Will be used as induction dosing, and 2) One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, C-reactive protein [CRP]), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: a) Will be used as a maintenance dose following the intravenous induction doses, OR b) Both of the following: 1) Will be used as induction dosing, and 2) One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A

Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All Indications (Initial): 6 months, (reauth): 12 months
Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRIKAFTA (S)

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). CFTR mutation is responsive based on clinical and/or in vitro data OR CFTR mutation results in the production of CFTR protein.
Age Restrictions	CF (initial): For granule packets: patient is at least 2 to less than 6 years of age. For tablets: patient is 6 years of age or older.
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIPTODUR (S)

Products Affected

- Triptodur

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range. Trial and failure or intolerance to Lupron Depot-Ped.
Age Restrictions	N/A
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (initial, reauth): 12 months
Other Criteria	CPP (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRODELVY (S)

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUDHESA (S)

Products Affected

- Trudhesa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRULICITY (S)

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUQAP (S)

Products Affected

- Truqap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy). Prostate Cancer: Diagnosis of prostate cancer. Disease is metastatic. Used in combination with abiraterone and prednisone. Disease is androgen pathway modulation-naïve or -sensitive (mAPMN/S). Tumor is PTEN deficient as detected by a FDA approved test or a test performed at a facility approved by Clinical Laboratory Amendments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: 12 months
Other Criteria	All indications: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRUTAKNA (S)

Products Affected

- Trutakna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool). Used to reduce proteinuria.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a nephrologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUXIMA (S)

Products Affected

- Truxima

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Hodgkin's Lymphoma (NHL): One of the following: 1) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Used as first-line treatment in combination with chemotherapy, 2) Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma. Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy. Used as monotherapy for maintenance therapy, 3) Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma. One of the following: a) Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy or, b) Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy, 4) Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma, 5) Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, OR 6) Diagnosis of one of the following previously untreated, advanced stage indications: a) CD-20-positive diffuse large B-cell lymphoma, b) Burkitt lymphoma, c) Burkitt-like lymphoma, or d) mature B-cell acute leukemia. Patient is 6 months of age or older. Used in combination with chemotherapy. Chronic Lymphocytic Leukemia (CLL): Diagnosis of chronic lymphocytic leukemia. Used in combination with fludarabine and cyclophosphamide. Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV.
Age Restrictions	N/A

Prescriber Restrictions	NHL, CLL: Prescribed by or in consultation with a hematologist/oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist. PV: Prescribed by or in consultation with a dermatologist.
Coverage Duration	NHL, CLL, PV: 12 months. WG, MPA: 3 months. RA: 1 month.
Other Criteria	Rheumatoid Arthritis (RA): Diagnosis of moderately to severely active RA. Used in combination with methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab). Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Diagnosis of WG or MPA. Used in combination with glucocorticoids (e.g., prednisone). All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRYNGOLZA (S)

Products Affected

- Tryngolza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Familial Chylomicronemia syndrome (FCS) (Initial): Diagnosis of FCS (type 1 hyperlipoproteinemia). One of the following: a) Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1), b) A North American FCS (NAFCS) Score of greater than or equal to 45, or c) A Moulin score greater than 10. Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug. Severe hypertriglyceridemia (Initial): Diagnosis of severe hypertriglyceridemia. Baseline fasting triglyceride levels prior to treatment with requested drug are greater than or equal to 500 mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	All uses (Initial): Prescribed by or in consultation with a cardiologist, endocrinologist, gastroenterologist, or lipid specialist (lipidologist).
Coverage Duration	All uses (Initial, Reauth): 12 months.
Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TUKYSA (S)

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) advanced unresectable or b) metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Used in combination with trastuzumab and capecitabine. Patient has received one or more prior anti-HER2 based regimens (e.g., trastuzumab, pertuzumab, ado-trastuzumab emtansine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TURALIO (S)

Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tenosynovial Giant Cell Tumor (TGCT): Diagnosis of TGCT. Patient is symptomatic. Patient is not a candidate for surgery due to worsening functional limitation or severe morbidity with surgical removal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYENNE IV (S)

Products Affected

- Tyenne INJ 200MG/10ML, 400MG/20ML, 80MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib), or b) attestation demonstrating a trial may be inappropriate, OR c) For continuation of prior therapy. Systemic Juvenile Idiopathic arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. Cytokine Release Syndrome (CRS): Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [e.g., Kymriah (tisagenlecleuce), Yescarta (axicabtagene ciloleucel)]. Coronavirus disease 2019 (COVID-19): Diagnosis of COVID-19. Patient is hospitalized. Currently receiving systemic corticosteroids. Patient requires one of the following: supplemental oxygen, non-invasive mechanical ventilation, invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA, GCA (initial): Prescribed by or in consultation with a rheumatologist. CRS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration	RA, SJIA, PJIA, GCA (Init): 6 mo, (reauth): 12 mo. CRS: 2 mo. COVID-19: 14 days.
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GCA (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYENNE SC (S)

Products Affected

- Tyenne INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq/LQ, or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.
Age Restrictions	N/A

Prescriber Restrictions	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months
Other Criteria	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYKERB (S)

Products Affected

- Lapatinib Ditosylate
- Tykerb

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer. Disease is one of the following: advanced, metastatic, or recurrent. Used in combination with one of the following: Trastuzumab, Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYMLOS (S)

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following diagnoses: 1) postmenopausal osteoporosis or osteopenia, OR 2) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, or Set III) History of fragility fracture (e.g., hip or spine) regardless of BMD. Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (max 24 months of therapy per lifetime)

Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYSABRI (S)

Products Affected

- Tysabri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance (TF/C/I) to one disease-modifying therapy for MS (e.g., Gilenya [fingolimod], Avonex [Interferon beta-1a], Betaseron [Interferon beta-1b]), 2) Patient is not a candidate for any of the drugs listed as prerequisites due to the severity of their MS, or 3) for continuation of prior therapy. MS (init, reauth): Not used in combination with another disease-modifying therapy for MS. Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). TF/C/I to one of the following conventional therapies: corticosteroids (eg, prednisone), 6-mercaptopurine, azathioprine, methotrexate. TF/C/I to a TNF-inhibitor (eg, adalimumab). CD (initial and reauth): Not used in combination with TNF inhibitors (e.g., adalimumab) or immunosuppressants (eg, 6-MP, azathioprine, cyclosporine, or methotrexate).
Age Restrictions	N/A
Prescriber Restrictions	MS (init, reauth): Prescribed by or in consultation with a neurologist. CD (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (init, reauth): 12mo. CD (Init): 3 mo. CD (Reauth): 12 mo.
Other Criteria	MS, CD (reauth): Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYVASO (S)

Products Affected

- Tyvaso
- Tyvaso Refill Kit
- Tyvaso Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD) (Initial): Diagnosis of PH-ILD. Diagnosis of PH-ILD was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging).
Age Restrictions	N/A
Prescriber Restrictions	PAH, PH-ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, PH-ILD: Initial: 6 months. Reauth: 12 months.
Other Criteria	Subject to Part B vs D review. PAH, PH-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYVASO DPI (S)

Products Affected

- Tyvaso Dpi Institutional Kit
- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD) (Initial): Diagnosis of PH-ILD. Diagnosis of PH-ILD was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging).
Age Restrictions	N/A
Prescriber Restrictions	PAH, PH-ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, PH-ILD: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, PH-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

UBRELVY (S)

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient has experienced a positive response to therapy. Will not be used for preventive treatment of migraine. Medication will not be used in combination with another CGRP inhibitor for the acute treatment of migraines.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UDENYCA (S)

Products Affected

- Udenyca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

UDENYCA ONBODY (S)

Products Affected

- Udenyca Onbody

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ULTOMIRIS (S)

Products Affected

- Ultomiris INJ 1100MG/11ML, 300MG/3ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Paroxysmal nocturnal hemoglobinuria (PNH) (initial): Diagnosis of PNH. Atypical hemolytic uremic syndrome (aHUS) (initial): Diagnosis of aHUS. Generalized myasthenia gravis (gMG) (initial): Diagnosis of gMG. Patient is anti-acetylcholine receptor (AChR) antibody positive. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and TF/C/I to chronic plasmapheresis/plasma exchange (PE) or intravenous immunoglobulin (IVIG). Neuromyelitis optica spectrum disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive.
Age Restrictions	PNH, aHUS (initial): Patient is one month of age or older.
Prescriber Restrictions	PNH (initial): Prescribed by or in consultation with a hematologist/oncologist. aHUS (initial): Prescribed by or in consultation with a hematologist or nephrologist. gMg (initial): Prescribed by or in consultation with a neurologist. NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist.
Coverage Duration	PNH, aHUS, gMG, NMOSD (initial, reauth): 12 months
Other Criteria	PNH, aHUS, gMG, NMOSD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UNDECATREX (S)

Products Affected

- Undecatrex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

Other Criteria	HG (init): Trial and failure or intolerance to generic testosterone gel. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UNITUXIN (S)

Products Affected

- Unituxin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

UPTRAVI (S)

Products Affected

- Uptravi TABS
- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UPTRAVI INJECTION (S)

Products Affected

- Uptravi INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy. Not taken in combination with a prostanoid/prostacyclin analogue [e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)]. Patient is unable to take oral medications.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy. Not taken in combination with a prostanoid/prostacyclin analogue [e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)].
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

USTEKINUMAB (IV) (S)

Products Affected

- Ustekinumab INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One time
Other Criteria	Will be administered as an intravenous induction dose. Induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

USTEKINUMAB (S)

Products Affected

- Ustekinumab INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose. Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. All indications (initial): Trial of either Steqeyma or Wezlana.
Age Restrictions	Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older.
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): 12 months.
Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VABRINTY (S)

Products Affected

- Vabrinty

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial, contraindication, or intolerance to any brand Lupron formulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VABYSMO (S)

Products Affected

- Vabysmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following diagnoses: A) neovascular (wet) age-related macular degeneration (nAMD), B) diabetic macular edema (DME), OR C) macular edema following retinal vein occlusion. Trial and failure, contraindication, or intolerance to compounded bevacizumab prepared by a 503(B) Outsourcing Facility OR Lucentis (ranibizumab).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., Improvement in Best Corrected Visual Acuity (BCVA) compared to baseline, stable vision).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VAFSEO (S)

Products Affected

- Vafseo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of chronic kidney disease (CKD). Patient has been on dialysis for at least 3 months. Adequate iron stores confirmed by both of the following: a) Patient's ferritin level is greater than 100 mcg/L, and b) Patient's transferrin saturation (TSAT) is greater than 20%. Hemoglobin level less than 11 g/dL. Trial and failure, contraindication, or intolerance to one erythropoeitin stimulating agent (ESA) (e.g., Retacrit, Procrit). Patient is not on concurrent treatment with an ESA (e.g., Aranesp, Epogen, Procrit).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist or nephrologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Subject to ESRD review. Reauth: Patient demonstrates positive clinical response to therapy. Hemoglobin level does not exceed 11 g/dL. Adequate iron stores confirmed by both of the following: a) Patient's ferritin level is greater than 100 mcg/L, and b) Patient's transferrin saturation (TSAT) is greater than 20%. Patient is not on concurrent treatment with an ESA (e.g., Aranesp, Epogen, Procrit).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VALCHLOR (S)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy (e.g., topical corticosteroids [e.g., clobetasol, fluocinonide], bexarotene topical gel [Targretin topical gel], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VANFLYTA (S)

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Patient has a FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (FLT3-ITD) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: a) Used in combination with standard cytarabine and anthracycline (e.g., daunorubicin, idarubicin) induction and cytarabine consolidation, and b) Used as maintenance monotherapy following consolidation chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VANRAFIA (S)

Products Affected

- Vanrafia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk for disease progression. Used to reduce proteinuria. Patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following: a) An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), OR b) An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a nephrologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VARIZIG (S)

Products Affected

- Varizig INJ 125UNIT/1.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Presence of contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication).
Required Medical Information	Immune globulin is being used intramuscularly. The immune globulin is being used for passive immunization or post exposure-prophylaxis of varicella. Patient is considered a high risk individual (i.e., immune compromised, pregnant woman, newborn of mother with varicella, premature infant, and infant less than 1 year old).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months (approve one dose only)
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VEGZELMA (S)

Products Affected

- Vegzelma

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Trial and failure, or intolerance to Mvasi (bevacizumab-awwb) and Zirabev (bevacizumab-bvzr). Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VELSIPITY (S)

Products Affected

- Velsipity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib/ER), OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (initial): 6 months, (reauth): 12 months.
Other Criteria	UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VENCLEXTA (S)

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Acute Myeloid Leukemia (AML): Diagnosis of newly diagnosed AML. Used in combination with azacitidine, or decitabine, or low-dose cytarabine. One of the following: 1) age 75 years or older OR 2) comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VENTAVIS (S)

Products Affected

- Ventavis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. (Reauth): 12 months
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VEOPOZ (S)

Products Affected

- Veopoz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of active CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease. Patient has a confirmed genotype of biallelic CD55 loss-of-function mutation. Patient has hypoalbuminemia (serum albumin concentration of less than or equal to 3.2 g/dL). Patient has at least one of the following signs or symptoms within the last six months: abdominal pain, diarrhea, peripheral edema, or facial edema.
Age Restrictions	Initial: Patient is 1 year of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with an immunologist, geneticist, hematologist, or gastroenterologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VEOZAH (S)

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe vasomotor symptoms due to menopause. Prescriber attests that baseline serum alanine aminotransferase (ALT), serum aspartate aminotransferase (AST) and total bilirubin levels are less than 2 times the upper limit of normal (ULN) prior to initiating Veozah.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. One of the following: 1) If patient has been on therapy for less than 9 months, provider attests to one of the following within the past 3 months: a) For patients with total bilirubin levels less than or equal to 2 times the ULN, transaminase elevations do not exceed 5 times the ULN, or b) For patients with total bilirubin levels greater than 2 times the ULN, transaminase elevations do not exceed 3 times the ULN, or 2) If patient has been on therapy for greater than or equal to 9 months, provider attests to both of the following: a) No hepatic issues arose during the first 9 months of therapy, and b) Patient does not currently have any hepatic related issues (e.g., signs or symptoms of hepatic strain).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VERKAZIA (S)

Products Affected

- Verkazia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of vernal keratoconjunctivitis confirmed by the presence of clinical signs and symptoms (e.g., itching, photophobia, giant papillae at the upper tarsal conjunctiva or at the limbus, thick mucus discharge, conjunctival hyperaemia). Trial and failure, contraindication, or intolerance to ONE of the following: a) Topical ophthalmic "dual-acting" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine), OR b) Topical ophthalmic mast cell stabilizers (e.g., cromolyn). Trial and failure, contraindication, or intolerance for short-term use (for up to 2 to 3 weeks) of topical ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluoromethalone).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in clinical signs and symptoms of itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERQUVO (S)

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Heart Failure (CHF) (initial): Diagnosis of CHF. Patient has an ejection fraction less than 45 percent. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. One of the following: A) Patient was hospitalized for heart failure within the last 6 months, or B) Patient used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months. Trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), 2) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), or 3) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)], B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone].
Age Restrictions	N/A
Prescriber Restrictions	CHF (initial): Prescribed by or in consultation with a cardiologist.
Coverage Duration	CHF (initial, reauth): 12 months
Other Criteria	CHF (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERZENIO (S)

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VEVYE (S)

Products Affected

- Vevye

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of dry eye disease. Trial and failure, contraindication, or intolerance to one of the following: a) Restasis (cyclosporine 0.05%), b) Xiidra (lifitegrast), or c) Tyrvaya (varenicline solution).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIBERZI (S)

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D. Trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	IBS-D (initial): 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	IBS-D (initial): 12 mo. IBS-D (reauth): 12 mo.
Other Criteria	IBS-D (reauth): Symptoms of IBS-D continue to persist. Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIGAFYDE (S)

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial or intolerance to generic vigabatrin.
Age Restrictions	Patient is 1 month to 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIJOICE (S)

Products Affected

- Vijoice

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of PIK3CA-related overgrowth spectrum (PROS). Patient demonstrates mutation in the PIK3CA gene. Patient demonstrates severe clinical manifestations (e.g., congenital lipomatous overgrowth, vascular malformations, epidermal nevi, scoliosis/skeletal and spinal [CLOVES], facial infiltrating lipomatosis [FIL], klippel-trenaunay syndrome [KTS], megalencephaly-capillary malformation polymicrogyria [MCAP]).
Age Restrictions	Initial: Patient is 2 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a physician who specializes in the treatment of PROS.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VILTEPSO (S)

Products Affected

- Viltepso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Duchenne muscular dystrophy (DMD). Presence of a mutation of the dystrophin gene amenable to exon 53 skipping as detected by a Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly. Patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair).
Age Restrictions	Initial: Patient is 4 years of age or older.
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient is tolerating therapy. Dose will not exceed 80 mg/kg of body weight infused once weekly.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VIMIZIM (S)

Products Affected

- Vimizim

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis (initial): Diagnosis of Mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome) confirmed by both of the following: a) documented clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.) and b) documented reduced fibroblast or leukocyte GALNS enzyme activity or molecular genetic testing for mutations in the GALNS gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VIMOVO (S)

Products Affected

- Naproxen/esomeprazole Magnesium
- Vimovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	(initial): Diagnosis of one of the following: a) osteoarthritis, b) rheumatoid arthritis, c) ankylosing spondylitis, OR d) juvenile idiopathic arthritis. Trial and failure, or intolerance to esomeprazole and naproxen sodium administered together as separate components.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial, reauth): 3 months.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VITRAKVI (S)

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Presence of solid tumors. One of the following: 1) Diagnosis of secretory breast cancer, mammary analogue secretory cancer (MASC), congenital mesoblastic nephroma (CMN), or infantile fibrosarcoma, or 2) Both of the following: i) Disease is confirmed by the presence of neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and ii) Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]. Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIVJOA (S)

Products Affected

- Vivjoa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent vulvovaginal candidiasis (RVVC). Patient is NOT of reproductive potential. Diagnosis of RVVC confirmed by one of the following: a) Positive potassium hydroxide (KOH) preparation or b) Vaginal fungal culture. Patient has experienced three or more symptomatic episodes of vulvovaginal candidiasis (VVC) within the past 12 months. Trial and failure, contraindication, or intolerance to both of the following: a) One intravaginal product (e.g., clotrimazole, miconazole, tioconazole, terconazole, boric acid) and b) Oral fluconazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIZIMPRO (S)

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Disease is positive for one of the following epidermal growth factor receptor (EGFR) mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA): exon 19 deletion or exon 21 L858R substitution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VONJO (S)

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Pre-treatment platelet count below 50 x 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOQUEZNA (S)

Products Affected

- Voquezna
- Voquezna Dual Pak
- Voquezna Triple Pak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Helicobacter pylori (H. pylori) (Voquezna Dual Pak, Voquezna Triple Pak): Diagnosis of H. pylori infection. Trial and failure, contraindication, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). H. pylori (Voquezna): Diagnosis of H. pylori infection. One of the following: a) Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection, or b) Used in combination with amoxicillin for the treatment of H. pylori infecion. Trial and failure, contraindication, or intolerance to bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). Healing and Relief of Heartburn associated with Erosive Esophagitis (HRH) (Voquezna): Diagnosis of erosive esophagitis. Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, e) rabeprazole, or f) dexlansoprazole. Maintenance of Healing and Relief of Heartburn associated with Erosive Esophagitis (MHRH) (Voquezna): Used to maintain healing and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, e) rabeprazole, or f) dexlansoprazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	H. pylori, NERD: 1 mo. HRH: 2 months. MHRH: 6 mos.

Other Criteria	Relief of Heartburn associated with Non-Erosive Gastroesophageal Reflux Disease (NERD): Diagnosis of non-erosive Gastroesophageal Reflux Disease. Both of the following: a) Patient has history of heartburn for at least 6 months and b) Heartburn symptoms are present for at least 4 days during any consecutive 7-day period. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, e) rabeprazole, or f) dexlansoprazole.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VORANIGO (S)

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of astrocytoma or oligodendroglioma. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORICONAZOLE INJECTION (S)

Products Affected

- Vfend IV
- Voriconazole INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOSEVI (S)

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOTRIENT (S)

Products Affected

- Pazopanib Hydrochloride
- Votrient

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOWST (S)

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of two or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Dificid (fidaxomicin), 2) Patient has completed or is planning to complete the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days).
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VOXZOGO (S)

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Patient has open epiphyses. Diagnosis of achondroplasia as confirmed by one of the following: 1) Both of the following: a) Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis) and b) Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest), OR 2) Molecular genetic testing confirmed c.1138G to A or c.1138G to C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene. Patient did not have limb-lengthening surgery in the previous 18 months and does not plan on having limb-lengthening surgery while on Voxzogo therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a clinical geneticist, endocrinologist, or a physician who has specialized expertise in the management of achondroplasia.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient continues to have open epiphyses. Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOYXACT (S)

Products Affected

- Voyxact

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk of disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool). Used to reduce proteinuria. One of the following: a) Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with an angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril) or an angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR b) Patient has a contraindication or intolerance to both ACE inhibitors and ARBs.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a nephrologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates a positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VPRIV (S)

Products Affected

- Vpriv

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	Gaucher disease: Patient is 4 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Gaucher disease: 12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VTAMA (S)

Products Affected

- Vtama

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (PsO) (Initial): Diagnosis of plaque psoriasis. One of the following: a) Minimum duration of a 4-week trial and failure, contraindication, or intolerance (TF/C/I) to two of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus), or b) minimum duration of a 4-week TF/C/I to one of the following topical combination therapies: vitamin D analog/corticosteroid (eg, Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene). Atopic Dermatitis (AD) (Initial): Diagnosis of AD. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to two of the following: a) Medium or higher potency topical corticosteroid, b) Elidel (pimecrolimus) cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment.
Age Restrictions	AD (Initial): Patient is 2 years of age or older.
Prescriber Restrictions	PsO (Initial): Prescribed by or in consultation with a dermatologist. AD (Initial): Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	PsO, AD (Initial): 6 months, Reauth: 12 months
Other Criteria	PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: a) Reduction in body surface area involvement from baseline, b) Reduction in pruritus severity from baseline, or c) Improvement in quality of life from baseline.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VUITY (S)

Products Affected

- Pilocarpine Hydrochloride SOLN 1.25%
- Vuity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of presbyopia.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VUMERITY (S)

Products Affected

- Vumerity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
Required Medical Information	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist
Coverage Duration	MS (initial, reauth): 12 months
Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VYEPTI (S)

Products Affected

- Vyepti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	EM, CM (initial): 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
Other Criteria	EM, CM (reauth): Patient has experienced a positive response to therapy. Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYJUVEK (S)

Products Affected

- Vyjuvek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of dystrophic epidermolysis bullosa (DEB). Patient has mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Medication is being used for the treatment of wounds that require healing. One of the following: a) Medication will be applied by a healthcare professional or b) Patient or caregiver has received training for the application of Vyjuvek. Wound(s) being treated has no signs of infection. Medication is not being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment of epidermolysis bullosa.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a dermatologist or specialist with expertise in wound care.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Wound(s) being treated has no signs of infection. Medication is not being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment of epidermolysis bullosa.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYKAT XR (S)

Products Affected

- Vykat Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of Prader-Willi syndrome (PWS). Medication is being used for hyperphagia due to PWS. Disease is confirmed by the presence of a mutation in chromosome 15 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	Initial: Patient is 4 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: a) Endocrinologist, b) Geneticist, or c) Specialist knowledgeable in the treatment of Prader-Willi syndrome.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYLOY (S)

Products Affected

- Vyloy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYONDYS (S)

Products Affected

- Vyondys 53

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following: a) diagnosis of Duchenne muscular dystrophy (DMD) and b) Presence of a mutation of the dystrophin gene amenable to exon 53 skipping. Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly. Submission of medical records (e.g., chart notes, laboratory values) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient is tolerating therapy, dose will not exceed 30 mg/kg of body weight infused once weekly, and submission of medical records (e.g., chart notes, laboratory values) confirming the patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VYSCOXA (S)

Products Affected

- Vyscoxa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of one of the following: 1) Osteoarthritis, 2) Rheumatoid arthritis, 3) Ankylosing spondylitis, or 4) Juvenile rheumatoid arthritis. One of the following: 1) Intolerance to generic celecoxib capsule or 2) Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VYVGART (S)

Products Affected

- Vyvgart Hytrulo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Generalized myasthenia gravis (gMG) (Initial): Diagnosis of gMG. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and TF/C/I to chronic plasmapheresis/plasma exchange (PE) or intravenous immunoglobulin (IVIG). Chronic inflammatory demyelinating polyneuropathy (CIDP) (Only applies for Vyvgart Hytrulo) (Initial): Diagnosis of CIDP as confirmed by all of the following: 1) Progressive symptoms present for at least 2 months, 2) Symptomatic polyradiculoneuropathy as indicated by one of the following: a) Progressive or relapsing motor impairment of more than one limb OR b) Progressive or relapsing sensory impairment of more than one limb. Trial and failure, contraindication, or intolerance to one of the following standard of care treatments: corticosteroids (minimum 3 month trial duration), immunoglobulin, or plasma exchange.
Age Restrictions	N/A
Prescriber Restrictions	gMG (Initial): Prescribed by or in consultation with a neurologist. CIDP (Initial, Reauth): Prescribed by or in consultation with an immunologist, neurologist, or hematologist.
Coverage Duration	gMG (Initial, Reauth): 12 months. CIDP (Initial): 6 months, (Reauth): 12 months.
Other Criteria	gMG, CIDP (Reauth): Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VYVGART IV (S)

Products Affected

- Vyvgart

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Generalized myasthenia gravis (gMG) (Initial): Diagnosis of gMG. One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or 2) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and TF/C/I to chronic plasmapheresis/plasma exchange (PE) or intravenous immunoglobulin (IVIG).
Age Restrictions	N/A
Prescriber Restrictions	gMG (Initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	gMG (Initial, Reauth): 12 months.
Other Criteria	gMG (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VYXEOS (S)

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Newly diagnosed therapy related acute myeloid leukemia (t-AML): Diagnosis of t-AML. Acute myeloid leukemia myelodysplasia-related changes (AML-MRC): Diagnosis of AML-MRC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WAINUA (S)

Products Affected

- Wainua

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy. Presence of a transthyretin (TTR) mutation (e.g., V30M) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Presence of clinical signs and symptoms of the disease (e.g., neuropathy, quality of life). Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Vyndaqel).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WAKIX (S)

Products Affected

- Wakix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1) (initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Symptoms of cataplexy are present. Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2) (initial): Diagnosis (Dx) of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Symptoms of cataplexy are absent. Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present. Trial and failure, contraindication (e.g., not indicated for patient's age) or intolerance to both generic modafinil and generic armodafinil.
Age Restrictions	Narcolepsy without cataplexy (Narcolepsy Type 2) (initial): Patient is 6 years of age or older.
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial, reauth): 12 months.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WAYRILZ (S)

Products Affected

- Wayrilz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of persistent immune thrombocytopenia (ITP), chronic ITP, or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. One of the following: 1) Patient has had a prior splenectomy, OR 2) Trial and failure, contraindication, or intolerance to one of the following: a) corticosteroids (e.g., prednisone, methylprednisolone), or b) immunoglobulins (e.g., Gammagard, immune globulin [human]). Trial and failure, contraindication, or intolerance to generic eltrombopag olamine.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WELIREG (S)

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	von Hippel-Lindau (VHL) disease: Diagnosis of VHL disease. Patient requires therapy for one of the following: a) renal cell carcinoma (RCC), b) central nervous system (CNS) hemangioblastoma, or c) pancreatic neuroendocrine tumor (pNET). Patient does not require immediate surgery. Advanced Renal Cell Carcinoma Monotherapy: Diagnosis of advanced renal cell carcinoma. Disease has progressed after treatment with both of the following: a) One of the following: i) Programmed death receptor-1 (PD-1) inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab)], or ii) Programmed death-ligand 1 (PD-L1) inhibitor [e.g., Bavencio (avelumab), Imfinzi (durvalumab)], and b) Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Votrient (pazopanib), Inlyta (axitinib)]. Pheochromocytoma or Paraganglioma (PPGL): Diagnosis of Pheochromocytoma or Paraganglioma (PPGL). Disease is one of the following: a) locally advanced, b) unresectable, or c) metastatic. Renal Cell Carcinoma with a Clear Cell Component (ccRCC): Diagnosis of ccRCC. Used in combination with one of the following: a) pembrolizumab, or b) pembrolizumab and berahyaluronidase alfa-pmph. One of the following: a) Patient is at intermediate-high or high risk of recurrence following nephrectomy, or b) Used following nephrectomy and resection of metastatic lesions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WEZLANA (S)

Products Affected

- Wezlana INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn’s disease. Will be used as a maintenance dose following the intravenous induction dose.
Age Restrictions	Plaque psoriasis, PsA (Initial): Patient is 6 years of age or older.
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	All uses (Initial): 6 months. All uses (Reauth): 12 months.

Other Criteria	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. CD, UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WEZLANA IV (S)

Products Affected

- Wezlana INJ 130MG/26ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. Ulcerative Colitis (UC): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	One time
Other Criteria	Will be administered as an intravenous induction dose. Induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease/ulcerative colitis: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WIDAPLIK (S)

Products Affected

- Widaplik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hypertension. Trial, contraindication, or intolerance to two formulary generic drugs from the following different classes: a) Angiotensin converting enzyme (ACE)-inhibitor (e.g., benazepril, lisinopril) or angiotensin receptor blocker (ARB) (e.g., losartan, valsartan), b) Thiazide-type or thiazide-like diuretic (e.g., hydrochlorothiazide, chlorthalidone), or c) Calcium channel blocker (e.g., diltiazem).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WINLEVI (S)

Products Affected

- Winlevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acne (initial): Diagnosis of acne vulgaris (i.e., acne). Trial and inadequate response (of a minimum 30-day supply) within the past 180 days, contraindication, or intolerance to two of the following: i) generic adapalene (cream, gel, lotion), ii) generic topical tretinoin or tretinoin microsphere, iii) generic tazarotene cream, iv) generic single-agent topical clindamycin product, or v) generic dapsone gel.
Age Restrictions	Acne (initial): Patient is 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Acne (initial): 6 months. Acne (reauth): 12 months.
Other Criteria	Acne (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WINREVAIR (S)

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. Patient is currently on at least two therapies indicated for the treatment of PAH from the following different mechanisms of action, unless there is a contraindication or intolerance: a) Endopthelin receptor antagonists (ie, Bosentan, ambrisentan or macitentan) and b) Phosphodiesterase 5 inhibitors (ie, Tadalafil or sildenafil).
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WYOST (S)

Products Affected

- Wyost

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Skeletal prevention in Multiple Myeloma (MM)/Bone Metastasis from Solid Tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (e.g., breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. One of the following: 1) One of the following: a) tumor is unresectable or b) surgical resection is likely to result in severe morbidity, OR 2) Approve for continuation of prior therapy. Hypercalcemia of malignancy (HCM): Diagnosis of hypercalcemia of malignancy. Trial and failure, contraindication, or intolerance to one bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MM/BMST, GCTB, HCM: 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XALKORI (S)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) or B) Patient has ROS1 rearrangement-positive tumor as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Anaplastic Large Cell Lymphoma (ALCL): Diagnosis of systemic ALCL. Disease is relapsed or refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Inflammatory Myofibroblastic Tumor (IMT): Diagnosis of IMT. Disease is one of the following: a) unresectable, b) recurrent, or c) refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	IMT, ALCL: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XATMEP (S)

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL). Polyarticular juvenile idiopathic arthritis (pJIA): Diagnosis of polyarticular juvenile idiopathic arthritis.
Age Restrictions	N/A
Prescriber Restrictions	pJIA: Prescribed by or in consultation with a rheumatologist.
Coverage Duration	ALL, pJIA: 12 months.
Other Criteria	Subject to Part B vs D review. Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XCOPRI (S)

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XELJANZ (S)

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er
- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tofacitinib tab/Tofacitinib XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Tofacitinib tab and solution/Tofacitinib XR tab: Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Tofacitinib tab/Tofacitinib XR tab: Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). Tofacitinib tab/Tofacitinib XR tab: Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration	RA/PJIA/PsA/AS (initial): 6 mo, (reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.
Other Criteria	Tofacitinib: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, PJIA (Initial): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. RA, PsA, AS, PJIA (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XENAZINE (S)

Products Affected

- Tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication, OR 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Trial and failure, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	N/A
Prescriber Restrictions	HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	All indications (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XENPOZYME (S)

Products Affected

- Xenpozyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of acid sphingomyelinase deficiency (ASMD). Disease confirmed by ONE of the following: a) Molecular genetic testing confirms biallelic pathogenic variants in the SMPD1 (sphingomyelin phophodiesterase-1) gene OR b) Residual acid sphingomyelinase activity that is less than 10% of controls (in peripheral blood lymphocytes or cultured skin fibroblasts). Patient has non-central nervous system manifestations of ASMD.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a metabolic disease specialist or geneticist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy (e.g., decrease in spleen size, decrease in liver size, increase in platelet count, improved lung function).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XEOMIN (S)

Products Affected

- Xeomin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (initial): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. Upper limb spasticity (ULS) (initial): Diagnosis of upper limb spasticity. Chronic Sialorrhea (CS) (initial): Diagnosis of chronic sialorrhea.
Age Restrictions	ULS, CS (initial): Patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All indications (initial): 3 months, (reauth): 12 months.
Other Criteria	CD, blepharospasm, ULS (reauth): Patient demonstrates positive clinical response to therapy. At least 3 months have elapsed or will have elapsed since the last treatment. CS (reauth): Patient demonstrates positive clinical response to therapy. At least 4 months have elapsed or will have elapsed since the last treatment.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XERMELO (S)

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Carcinoid syndrome diarrhea (Initial): Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months AND used in combination with SSA therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Carcinoid syndrome diarrhea (Reauthorization): Patient demonstrates positive clinical response to therapy AND drug will continue to be used in combination with SSA therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XGEVA (S)

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) Diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) Diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MM/BMST, GCTB, HCM: 12 mo.
Other Criteria	GCTB: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XIAFLEX (S)

Products Affected

- Xiaflex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dupuytren's contracture (DC) (initial, reauth): Diagnosis of Dupuytren's contracture with a palpable cord AND Patient has a positive "table top test" (defined as the inability to simultaneously place the affected finger and palm flat against a table top) AND Patient has a documented contracture of at least 20 degrees flexion for a metacarpophalangeal joint or a proximal interphalangeal joint AND Patient has a flexion deformity that results in functional limitations. Peyronie's disease (PD) (initial, reauth): Diagnosis of Peyronie's disease AND Patient has a palpable plaque and curvature deformity of at least 30 degrees at the start of therapy AND The plaques do not involve the penile urethra AND Patient has a curvature deformity that results in pain (e.g., pain upon erection or intercourse).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	DC, PD (Initial and reauth): 12 months
Other Criteria	Peyronie's disease (reauth): patient has a new plaque that results in a curvature deformity.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XIFAXAN (S)

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Travelers' diarrhea (TD): Diagnosis of travelers' diarrhea. One of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis (ppx) of hepatic encephalopathy (HE) recurrence (initial): Used for the prophylaxis of hepatic encephalopathy recurrence, AND One of the following: 1) Trial and failure, contraindication or intolerance to lactulose or 2) Add-on treatment to lactulose. Treatment (tx) of HE: Used for the treatment of HE. One of the following: 1) Trial and failure, contraindication, or intolerance to lactulose or 2) Add-on treatment to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TD: 14 days. HE (tx): 12 months. HE (ppx) (init, reauth): 12 months. IBS-D (init, reauth): 2 weeks.
Other Criteria	Prophylaxis of HE recurrence (reauth): Patient demonstrates positive clinical response to therapy. IBS-D (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XIPERE (S)

Products Affected

- Xipere

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of macular edema due to uveitis is confirmed by ONE of the following tests: a) Slit lamp exam, b) Fundoscopic exam, c) Fluorescein angiography, or d) Optical coherence tomography (OCT). Patient is free of ocular and peri-ocular infections. Patient does not have untreated intraocular pressure or uncontrolled glaucoma. Trial and failure, contraindication or intolerance to at least ONE other corticosteroid (e.g., methylprednisolone, Ozurdex, prednisolone, prednisone, triamcinolone). Patient has not received any of the following sustained-release intravitreal corticosteroids: a) Dexamethasone (e.g., Ozurdex) within the past 6 months, or b) Fluocinolone acetonide within the past 30 months (e.g., Retisert) or 36 months (e.g., Iluvien, Yutiq).
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLAIR (S)

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Asthma (init): Diagnosis of moderate to severe persistent allergic asthma. Positive skin test or in vitro reactivity to a perennial aeroallergen. One of the following: A) All of the following: a) Patient is 6 years of age or older but less than 12 years of age, b) Pretreatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100-200 mcg fluticasone propionate equivalent/day), and 2) Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR ii) One medium dosed combination ICS/LABA product (eg, Wixela Inhub [fluticasone propionate 100mcg/salmeterol 50mcg], budesonide 80mcg/formoterol 4.5mcg, Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]), OR B) All of the following: a) Patient is 12 years of age or older, b) Treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day], and 2) Additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR ii) One maximally-dosed combination ICS/LABA product [eg, Wixela Inhub (fluticasone propionate 500mcg/salmeterol 50mcg), budesonide 160mcg/ formoterol 4.5mcg, Breo Ellipta (fluticasone 200mcg/vilanterol 25mcg)].
Age Restrictions	IgE-Mediated Food Allergy (init): Patient is 1 year of age or older.

Prescriber Restrictions	Asthma (init): Prescribed by or in consultation with an allergist/immunologist, or pulmonologist. CSU (init): Prescribed by or in consultation with an allergist/immunologist, or dermatologist. CRSwNP (init/reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. IgE-Mediated Food Allergy (Init/Reauth): Prescribed by or in consultation with an allergist/immunologist.
Coverage Duration	Asthma, CSU, Allergy (init, reauth): 12 months. CRSwNP: 12 months.
Other Criteria	Asthma (reauth): Patient demonstrates positive clinical response to therapy. Chronic Spontaneous Urticaria (CSU) (init): Diagnosis of CSU. Persistent symptoms (itching and hives) with a second generation H1 antihistamine (eg, cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines. Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. CSU (reauth): Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline. Chronic Rhinosinusitis with Nasal polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for chronic rhinosinusitis with nasal polyps. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for chronic rhinosinusitis with nasal polyps. IgE-Mediated Food Allergy (Initial): One of the following: A) Both of the following: 1) Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following: a) Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food, b) Positive food specific IgE (greater than or equal to 6 kUA/L), c) Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein, AND 2) Clinical history of IgE Mediated Food Allergy, OR B) Provider attestation that patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods. Used in conjunction with food allergen avoidance. Baseline (pre-Xolair tx) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL. Dosing is according to serum total IgE levels and body weight. IgE-Mediated Food Allergy (Reauth): Patient demonstrates positive clinical response to therapy. Used in conjunction with food allergen avoidance. Dosing will continue to be based on body weight and pretreatment total IgE serum levels.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLREMDI (S)

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Patient has genotype confirmed variant of CXCR4 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has an absolute neutrophil count (ANC) less than 500 cells/µL.
Age Restrictions	Initial: Patient is 12 years of age or older.
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: immunologist, hematologist, geneticist, dermatologist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XOSPATA (S)

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Patient has a FMS-like tyrosine kinase (FLT3) mutation as determined by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XPHOZAH (S)

Products Affected

- Xphozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hyperphosphatemia in chronic kidney disease. Patient is on dialysis. Trial and inadequate response, contraindication or intolerance to two of the following: a) calcium carbonate, b) calcium acetate, c) lanthanum carbonate, d) sevelamer carbonate, or e) sevelamer HCl.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Subject to ESRD review. Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XPOVIO (S)

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Multiple Myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XROMI (S)

Products Affected

- Xromi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of sickle cell anemia. Patient has moderate to severe painful crises. One of the following: a) patient is unable to swallow solid oral dosage forms (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), OR b) dosage requirements cannot be met with a solid dosage form.
Age Restrictions	Initial: Patient is 6 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XTANDI (S)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic castration-sensitive prostate cancer. Non-metastatic castrion-sensitive prostate cancer (nm-CSPC): Diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC). Patient has high-risk biochemical recurrence (BCR) defined by a PSA doubling time less than or equal to 9 months and one of the following: A) PSA values greater than or equal to 1 ng/mL if the patient had prior prostatectomy (with or without radiotherapy) OR B) PSA values at least 2 ng/mL above the nadir if the patient had prior radiotherapy only.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XURIDEN (S)

Products Affected

- Xuriden

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hereditary orotic aciduria (Initial): Diagnosis of hereditary orotic aciduria.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a medical geneticist or other specialist that treats inborn errors of metabolism
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Hereditary orotic aciduria (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XYREM (S)

Products Affected

- Sodium Oxybate
- Xyrem

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND One of the following: a) patient is under 18 years of age or b) trial and failure, contraindication or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
Age Restrictions	All Indications (initial): Patient is 7 years of age or older.
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months
Other Criteria	All uses (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XYWAV (S)

Products Affected

- Xywav

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND one of the following: 1) both of the following: A) patient is 18 years of age or older, and B) trial and failure, contraindication or intolerance to both of the following: i) generic modafinil, AND ii) generic armodafinil, OR 2) patient is 7 to 17 years of age. Idiopathic Hypersomnia (IH)(initial): Diagnosis of idiopathic hypersomnia as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of excessive daytime sleepiness (e.g., nap duration of longer than 60 minutes) are present.
Age Restrictions	Narcolepsy Type 1 (initial): Patient is 7 years of age or older.
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
Coverage Duration	All uses (initial): 6 months. All uses (reauth): 12 months

Other Criteria	Narcolepsy with cataplexy (Narcolepsy Type 1)(reauth): Patient demonstrates a reduction in the frequency of cataplexy attacks associated with therapy, OR patient demonstrates a reduction in symptoms of excessive daytime sleepiness associated with therapy. Narcolepsy without Cataplexy (Narcolepsy Type 2)(reauth): Patient demonstrates a reduction in symptoms of excessive daytime sleepiness associated with therapy. Idiopathic Hypersomnia (IH)(reauth): Patient demonstrates a reduction in symptoms of excessive daytime sleepiness associated with therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YERVOY (S)

Products Affected

- Yervoy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

YONSA (S)

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of castration-resistant (chemical or surgical) prostate cancer. Trial and failure or intolerance to Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YULITHIRA (S)

Products Affected

- Yulithira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma. Trial and failure, contraindication, or intolerance to Sutent (sunitinib) or Nexavar (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET. Disease is unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer. Trial and failure, contraindication, or intolerance to Femara (letrozole) or Arimidex (anastrozole). Neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin. Disease is unresectable, locally advanced, or metastatic.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months.
Other Criteria	All uses: Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YUTREPIA (S)

Products Affected

- Yutrepia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD) (Initial): Diagnosis of PH-ILD. Diagnosis of PH-ILD was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging).
Age Restrictions	N/A
Prescriber Restrictions	PAH, PH-ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, PH-ILD: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, PH-ILD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

YUVEZZI (S)

Products Affected

- Yuvezzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of presbyopia.
Age Restrictions	N/A
Prescriber Restrictions	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

YUVIWEL (S)

Products Affected

- Yuviwel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (e.g., chart notes) confirming diagnosis of achondroplasia by one of the following: 1) Both of the following: a) Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis) and b) Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest), OR 2) Disease is confirmed by the presence of c.1138G to A or c.1138G to C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has open epiphyses.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a clinical geneticist, endocrinologist, or a physician who has specialized expertise in the management of achondroplasia.
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient continues to have open epiphyses. Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZALTRAP (S)

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZAVESCA (S)

Products Affected

- Miglustat
- Yargesa
- Zavesca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease. Niemann-Pick disease type C (NPC) (off-label) (initial): Diagnosis of NPC. Requested drug will be used in combination with Miplyffa (arimoclomol).
Age Restrictions	Gaucher disease: Patient is 18 years of age or older.
Prescriber Restrictions	NPC (initial): Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C.
Coverage Duration	Gaucher disease: 12 months. NPC (initial): 6 months, (reauth): 12 months.
Other Criteria	NPC (reauth): Patient demonstrates positive clinical response to therapy. Requested drug will be used in combination with Miplyffa (arimoclomol).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZEJULA (S)

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZELBORAF (S)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	All indications: Approve for continuation of therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZELSUVMI (S)

Products Affected

- Zelsuvmi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of molluscum contagiosum. Patient is treating new lesions that have not previously been treated with Zelsuvmi. Medication is not being used concurrently with other FDA approved therapies (e.g., Ycanth) on the same lesion for the treatment of molluscum contagiosum.
Age Restrictions	Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZENBEXUS (S)

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma. Patient has received at least one prior line of therapy including both of the following: a) One proteasome inhibitor (e.g., bortezomib), and b) One immunomodulatory agent (e.g., pomalidomide, lenalidomide). Used in combination with both of the following: a) Darzalex (daratumumab) or Darzalex Faspro (daratumumab and hyaluronidase-fihj), and b) Dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEPATIER (S)

Products Affected

- Zepatier

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, ONE of the following: 1) Patient has a trial and failure, contraindication or intolerance to a) sofosbuvir/velpatasvir AND b) Mavyret, OR 2) For continuation of prior therapy. Patient does not have moderate to severe hepatic impairment (eg, Child-Pugh Class B or C). For genotype 1a, patient has been tested for the presence of NS5A resistance-associated polymorphisms (ie, polymorphisms at amino acid positions 28, 30, 31, or 93). One of the following: patient is 12 years of age or older OR patient weight is at least 30 kg.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine, Liver transplant specialist.
Coverage Duration	12 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEPOSIA (S)

Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Failure after a trial of at least 4 weeks, contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy. Ulcerative Colitis (UC) (init): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), one formulary ustekinumab product, Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib/ER), OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	MS (initial, reauth): Prescribed by or in consultation with a neurologist. UC (init): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	MS (initial, reauth): 12 months. UC (init): 6 months, (reauth): 12 months.

Other Criteria	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression). UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEPZELCA (S)

Products Affected

- Zepzelca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZIEXTENZO (S)

Products Affected

- Ziextenzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.
Age Restrictions	N/A
Prescriber Restrictions	All uses: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
Other Criteria	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta AND Udenyca.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZIIHERA (S)

Products Affected

- Ziihera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZILBRYSQ (S)

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of generalized myasthenia gravis (gMG). Patient is anti-acetylcholine receptor (AChR) antibody positive. One of the following: A) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or B) Both of the following: 1) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and 2) TF/C/I to one of the following: a) chronic plasmapheresis or plasma exchange (PE), or b) intravenous immunoglobulin (IVIG).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial, Reauth: 12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZIRABEV (S)

Products Affected

- Zirabev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOKINVY (S)

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with one of the following: i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m^2 and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOLADEX (S)

Products Affected

- Zoladex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer. Trial and failure, contraindication, or intolerance to Lupron Depot. Endometriosis [Zoladex (3.6 mg strength)]: Treatment of endometriosis. Trial and failure, contraindication, or intolerance to Lupron Depot. Advanced Breast Cancer [Zoladex (3.6 mg strength)]: For the palliative treatment of advanced breast cancer. Endometrial thinning [Zoladex (3.6 mg strength)] For the treatment of dysfunctional uterine bleeding. Used as an endometrial thinning agent prior to endometrial ablation.
Age Restrictions	Endometriosis: 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZOLINZA (S)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or contraindication or intolerance to two systemic therapies (e.g., bexarotene, romidepsin, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZORBTIVE (S)

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS): Diagnosis of SBS. Patient is currently receiving specialized nutritional support (eg, intravenous parenteral nutrition, fluid, and micronutrient supplements). Patient has not previously received 4 weeks of treatment with Zorbtive (somatropin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	SBS: 4 weeks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZORYVE (S)

Products Affected

- Zoryve CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Zoryve 0.3% Plaque psoriasis (PsO) (Initial): Diagnosis of plaque psoriasis. One of the following: a) Minimum duration of a 4 week trial and failure, contraindication, or intolerance (TF/C/I) to two of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, or calcineurin inhibitors (eg, tacrolimus, pimecrolimus), OR b) minimum duration of a 4 week TF/C/I to one of the following topical combination therapies: vitamin D analog/corticosteroid (eg, Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene). Zoryve 0.05%, 0.15% Atopic dermatitis (AD) (Initial): Diagnosis of mild to moderate AD. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following: a) Medium or higher potency topical corticosteroid, b) Elidel (pimecrolimus) cream, or c) Tacrolimus ointment.
Age Restrictions	AD 0.15% (initial): Patient is 6 years of age or older. AD 0.05% (initial): Patient is between 2 and 5 years of age.
Prescriber Restrictions	PsO (Initial): Prescribed by or in consultation with a dermatologist. AD (Initial): Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	PsO, AD (Initial): 6 months, Reauth: 12 months.
Other Criteria	PsO (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. AD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: a) Reduction in BSA involvement from baseline, b) Reduction in pruritus severity from baseline, or c) Improvement in quality of life from baseline.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZTALMY (S)

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene.
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZTLIDO (S)

Products Affected

- Ztlido

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia. Trial and failure or intolerance to generic lidocaine patch 5%.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZURZUVAE (S)

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): Diagnosis of PPD. Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYDELIG (S)

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Used in combination with Rituxan (rituximab). The patient has relapsed on at least one prior therapy (eg, purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]). Patient is a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZYKADIA (S)

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC that is metastatic or recurrent. Tumor is anaplastic lymphoma kinase (ALK)-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYNLONTA (S)

Products Affected

- Zynlonta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYNYZ (S)

Products Affected

- Zynyz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Merkel cell carcinoma (MCC). Disease is metastatic or recurrent locally advanced.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYTIGA (NON-PREFERRED) (S)

Products Affected

- Zytiga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-Resistant Prostate Cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Trial and failure, or intolerance to Xtandi (enzalutamide). Castration-Sensitive Prostate Cancer (CSPC): Diagnosis of castration-sensitive prostate cancer. Trial and failure, or intolerance to Xtandi (enzalutamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, CSPC: 12 months
Other Criteria	Approve for continuation of prior therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZYTIGA (PREFERRED) (S)

Products Affected

- Abiraterone Acetate TABS 250MG, 500MG
- Abirtega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Castration-Resistant Prostate Cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Castration-Sensitive Prostate Cancer (CSPC): Diagnosis of castration-sensitive prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRPC, CSPC: 12 months
Other Criteria	Approve for continuation of prior therapy
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 50MG
- Akynzeo CAPS
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Ambisome
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 405MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 750MG/100ML, 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 270MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 400MG/100ML; 200MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7% INJ 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 300MG/100ML; 570MG/100ML; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Anzemet TABS 50MG
- Aprepitant
- Astagraf XL
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Baclofen INJ 20000MCG/20ML, 40MG/20ML, 500MCG/ML, 50MCG/ML
- Bethkis
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cellcept
- Cellcept Intravenous
- Cladribine INJ
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix 8/14

- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 8/10
- Clinimix E 8/14
- Clinisol Sf 15%
- Clinolipid
- Clonidine Hydrochloride INJ
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Deferoxamine Mesylate
- Desferal INJ 500MG
- Dobutamine Hcl INJ 12.5MG/ML
- Dobutamine Hcl/d5w INJ 5%; 1MG/ML
- Dobutamine Hydrochloride/dextrose 5%
- Dopamine Hydrochloride INJ
- Dopamine Hydrochloride/dextrose
- Dopamine/d5w INJ 5%; 3.2MG/ML
- Doxorubicin Hcl INJ 2MG/ML, 50MG
- Doxorubicin Hydrochloride INJ 10MG
- Duraclon INJ 100MCG/ML
- Emend SUSR
- Emend Bipack
- Emend Tripack CPPK
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Favlyxa
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML, 25MCG/0.5ML, 500MCG/10ML, 50MCG/ML
- Floxuridine INJ
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Formoterol Fumarate NEBU
- Foscarnet Sodium INJ 6000MG/250ML
- Foscavir INJ 6000MG/250ML
- Gablofen
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Granisol
- Hepagam B INJ 312UNIT/ML
- Heplisav-b
- Hyperhep B
- Imovax Rabies (h.d.c.v.)
- Imuran TABS
- Infumorph 200
- Infumorph 500
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Kabiven
- Kitabis Pak
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- Levalbuterol Hydrochloride
- Lioresal Intrathecal

- Milrinone Lactate INJ 10MG/10ML, 20MG/20ML, 50MG/50ML
- Milrinone Lactate In Dextrose
- Mitigo
- Morphine Sulfate INJ 10MG/ML, 1MG/ML, 4MG/ML, 5MG/ML, 8MG/ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myfortic
- Myhibbin
- Nabi-hb INJ 312UNIT/ML
- Nebupent
- Neoral
- Nutrilipid
- Omegaven
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Pentamidine Isethionate INHALATION SOLR
- Perforomist
- Perikabiven
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prialt
- Prograf CAPS
- Prograf PACK
- Prosol
- Pulmicort
- Rabavert
- Rapamune
- Recombivax Hb
- Sandimmune CAPS 100MG, 25MG
- Sandimmune ORAL SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Smoflipid
- Tacrolimus CAPS
- Tacrolimus Er
- Tobi
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trimethobenzamide Hydrochloride CAPS

- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Varubi TBPK
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ 1MG/ML
- Yupelri
- Zortress

Details

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

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