ACTEMRA SQ

Products Affected

- Actemra ACTPen
- Actemra subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/GCA/PJIA - Prescribed by or in consultation with a rheumatologist.
Coverage Duration	GCA-6 mo initial, 3 yr cont.PJIA-4 mo initial, 3 yr cont.All other dx-3 mo initial, 3 yr cont.
Other Criteria	RA initial - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC) , or Xeljanz/XR (Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the 'try TWO' requirement: Cimzia, infliximab, golimumab SC/IV) OR if, according to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. PJIA, approve if the patient has tried etanercept, Orencia or adalimumb. (Note: the patient does not have to have a trial with etanercept, Orencia or adalimumb if they have had a trial with infliximab in the past.) Cont tx - pt must have had a response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ACTHAR

Products Affected

- Acthar

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for diagnostic procedure.
Required Medical Information	Diagnosis, prescriber or consulting physician specialty, previous medications tried and response
Age Restrictions	Infantile spasms- less than 2yo. Acute MS exac-adult
Prescriber Restrictions	Infantile spasms, prescr/consult w/neurolo/epileptologist.MS exacerbation, prescr/consult w/neuro/phys specializes MS.RA, JIA/JRA, AS, PsA, SLE, Systemic Dermatomyositis, prescr/consult w/rheum.Severe Erythema Multiforme, prescr/consult w/derm.Serum Sickness,prescr/consult w/ allergist.Severe acute/chronic allergic/inflamm processes of eye and its adnexa, prescr/consult w/ ophthalmologist.Symptomatic Sarcoidosis, prescr/consult w/pulm/cardio.Nephrotic Syndrome, prescr/consult w/nephrologist.
Coverage Duration	All diagnoses-1 month
Other Criteria	For acute MS exacerbation, approve if Acthar is NOT being used as pulse therapy on a monthly basis. For all other FDA approved diagnoses (other than Infantile spasms or MS exacerbation), approve if the patient has tried a systemic corticosteroid for the current condition and patient has experienced a severe adverse effect or treatment failure with the corticosteroid (e.g., a psychotic reaction).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ACYCLOVIR (TOPICAL)

Products Affected

- acyclovir topical cream
- acyclovir topical ointment
- Zovirax topical cream
- Zovirax topical ointment

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	Acyclovir 5% cream, 12 yrs or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	If the request is for brand name Zovirax 5% ointment, the patient is required to have tried generic acyclovir 5% ointment prior to approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer-HER2 status, hormone receptor (HR) status.
Age Restrictions	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Breast Cancer-approve if the patient meets ALL the following criteria (A, B, C, D, E, and F): A) pt has recurrent or Stage IV, hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease AND B) pt has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C) pt has tried at least one prior endocrine therapy (e.g., anastrozole, letrozole, or tamoxifen) AND D) pt meets ONE of the following conditions (i or ii): i. pt is a postmenopausal female or a male OR ii. pt is premenopausal or perimenopausal AND is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]), or has had surgical bilateral oophorectomy or ovarian irradiation AND E) The patient meets ONE of the following conditions (i or ii): i. If patient is a male AND if Afinitor will be used in combination with exemestane, the patient is receiving a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide], Trelstar [triptorelin], Zoladex (goserelin]) OR ii. Afinitor will be used in combination with exemestane, Faslodex (fulvestrant intramuscular), or tamoxifen AND F) The patient has not had disease progression while on Afinitor. Renal Cell Carcinoma (Clear Cell or Non-clear cell histology)-approve if the patient has relapsed or Stage IV disease and if using for clear cell disease, the patient has tried one prior systemic therapy (e.g., Inlyta, Votrient, Sutent, Cabometyx, Nexavar).Tuberous

PA Criteria	Criteria Details
	sclerosis complex (TSC) Associated subependymal giant cell astrocytoma (SEGA)-approve if the patient requires therapeutic intervention but cannot be curatively resected. Thymomas and Thymic Carcinomas-approve if the patient has tried one prior chemotherapy (e.g., cisplatin plus doxorubicin, cisplatin plus etoposide, carboplatin plus paclitaxel). TSC associated renal angiomyolipoma -approve. WM/LPL - approve if patient has progressive or relapsed disease or if the patient has not responded to ONE primary therapy (e.g., Velcade with dexamethasone with or without Rituxan, Treanda with Rituxan, Rituxan with cyclophosphamide and dexamethasone, Treanda, Velcade with or without Rituxan, Velcade with dexamethasone, Kyprolis with Rituxan and dexamethasone, Imbruvica Rituxan). Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma-approve if the patient is refractory to radioactive iodine therapy. Endometrial Carcinoma-approve if Afinitor will be used in combination with letrozole and the patient has recurrent, metastatic or high-risk disease. GIST-approve if the patient has tried TWO of the following drugs: Sutent, Stivarga, or imatinib AND there is confirmation that Afinitor will be used in combination with one of these drugs (Sutent, Stivarga, or imatinib) in the treatment of GIST.Tuberous sclerosis complex (TSC)-associated partial-onset seizures-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Advanced, unresectable or metastatic neuroendocrine tumors of the thymus (Carcinoid tumors). Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma, Endometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST) and Recurrent or progressive Meningioma, men with breast cancer

AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Ajovy or Emgality
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AJOVY

Products Affected

- Ajovy

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Aimovig or Emgality
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALUNBRIG

Products Affected

- Alunbrig oral tablet 180 mg, 30 mg, 90 mg
- Alunbrig oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	ALK status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AMPYRA

Products Affected

- Ampyra
- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANABOLIC STEROIDS

Products Affected

- Anadrol-50
- oxandrolone

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia

ANTIFUNGALS (IV)

Products Affected

- fluconazole in NaCl (iso-osm) intravenous piggyback 200 mg/100 mL, 400 mg/200 mL
- Vfend IV
- voriconazole intravenous

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARANESP

Products Affected

- Aranesp (in polysorbate) injection solution 100 mcg/mL, 200 mcg/mL, 25 mcg/mL, 300 mcg/mL, 40 mcg/mL, 60 mcg/mL
- Aranesp (in polysorbate) injection syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Anemia w/CRF on and not on dialysis.A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start,Hb has to be less than or equal 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA), Mircera or Aranesp. Anemia due to myelosuppressive chemotx,Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
Age Restrictions	MDS anemia = 18 years of age and older.
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Anemia w/myelosuppressive = 4 mos, Other=6 mos.
Other Criteria	For all covered uses, the patient is required to try Procrit first line.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndrome (MDS)

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent biologic therapy
Required Medical Information	N/A
Age Restrictions	Initial tx CAPS-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist.
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	CAPS renewal - approve if the patient has had a response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous medication history
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections
Coverage Duration	1 year
Other Criteria	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AUSTEDO

Products Affected

- Austedo oral tablet 12 mg, 6 mg, 9 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a psychiatrist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AVONEX

Products Affected

- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies, test results
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Urothelial Carcinoma, locally advanced or metastatic-approve if the patient has susceptible fibroblast growth factor receptor 3 or fibroblast growth factor receptor 2 genetic alterations AND the patient has progressed during or following prior platinum-containing chemotherapy
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BENLYSTA

Products Affected

- Benlysta subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other biologics or with cyclophosphamide intravenous (IV)
Required Medical Information	Diagnosis, medications that will be used in combination, autoantibody status
Age Restrictions	18 years and older (initial).
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation)
Coverage Duration	Initial-4 months, cont-3 years
Other Criteria	Initial-The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BETASERON/EXTAVIA

Products Affected

- Betaseron subcutaneous kit
- Extavia subcutaneous kit

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For patients requesting Extavia or Betaseron, approve if the patient has tried two of the following: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), pegylated interferon beta-1a (Plegridy) or glatiramer acetate (Copaxone).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BOSULIF

Products Affected

- Bosulif oral tablet 100 mg, 400 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Phildelphia chromosome positive Acute Lymphoblastic Leukemia

BRAFTOVI

Products Affected

- Braftovi oral capsule 75 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

C1 ESTERASE INHIBITORS

Products Affected

- Berinert intravenous kit
- Cinryze
- Haegarda
- Ruconest

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CABLIVI

Products Affected

- Cablivi injection kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent medications
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	3 months
Other Criteria	aTTP-approve if the patient is currently receiving at least one immunosuppressive therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, histology, RET gene rearrangement status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Advance Renal Cell Carcinoma (Predominant Clear Cell or Non-Clear Cell Histology)-Approve. Hepatocellular Carcinoma-approve if the patient has been previously treated with at least one other systemic therapy (e.g., Nexavar, Lenvima).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous medications/therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL and SLL-approve if the patient has tried one prior therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic Lymphocytic Leukemia (CLL). Plus Small Lymphocytic Lymphoma (SLL)

CAPRELSA

Products Affected

- Caprelsa oral tablet 100 mg, 300 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Non-Small Cell Lung Cancer with RET Gene Rearrangements

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
Other Criteria	Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency (NAGS) or if the patient has hyperammonemia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has has Pseudomonas aeruginosa in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHEMET

Products Affected

- Chemet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Blood lead level
Age Restrictions	Approve in patients between the age of 12 months and 18 years
Prescriber Restrictions	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
Coverage Duration	Approve for 2 months
Other Criteria	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHOLBAM

Products Affected

- Cholbam oral capsule 250 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Chenodal
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
Coverage Duration	3 mos initial, 12 mos cont
Other Criteria	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis or molecular genetic testing consistent with the diagnosis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS or molecular genetic testing consistent with the diagnosis AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improVement in steatorrhea) AND does not have complete biliary obstruction.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CIALIS

Products Affected

- Cialis oral tablet 2.5 mg, 5 mg
- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Indication for which tadalafil is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed as once daily dosing, to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CIMZIA

Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Adults for CD and PP.
Prescriber Restrictions	RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist.PsA prescribed by or in consultation with a rheumatologist or dermatologist. PP, prescribed by or in consultation with a dermatologist. nr-axSpA-prescribed by or in consultation with a rheumatologist
Coverage Duration	3 months initial, 3 years cont.
Other Criteria	AS, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia or Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. CD, approve if patient has previously tried Humira. Plaque Psoriasis-approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician. Non-radiographic axial spondylitis (nr-axSpA)-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI. nr-axSpA continuation-approve if the patient has had a response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CLOBAZAM

Products Affected

- clobazam oral suspension
- clobazam oral tablet
- Onfi oral suspension
- Onfi oral tablet 10 mg, 20 mg
- Sympazan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other medications tried
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Dravet Syndrome and treatment-refractory seizures/epilepsy

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

COPAXONE

Products Affected

- Copaxone subcutaneous syringe 20 mg/mL, 40 mg/mL
- glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL
- Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL/Follicular Lymphoma/SLL-approve if the patient has tried two prior therapies
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous use of a Beta-blocker, LVEF
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Chronic HF, adults- must have LVEF of less than or equal 35 percent AND tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). Heart failure due to dilated cardioimyopathy, children-approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COSENTYX

Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis and previous medications use
Age Restrictions	PP/AS/PSA initial - 18 years of age and older
Prescriber Restrictions	PP initial - prescribed by or in consultation with a dermatologist or rheumatologist. AS initial- by or in consultation with rheumatologist, PsA initial- by or in consultation with rheumatologist or dermatologist.
Coverage Duration	PP/AS - initial tx 3 mos, PsA-initial tx 3 mos, cont tx 3 years
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PP/AS/PsA cont - patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CRINONE GEL

Products Affected

- Crinone vaginal gel 8 %

PA Criteria	Criteria Details
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Support of an established pregnancy

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year
Other Criteria	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CYSTEAMINE (ORAL)

Products Affected

- Cystagon

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Cystagon and Procysbi
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DALIRESP

Products Affected

- Daliresp oral tablet 250 mcg, 500 mcg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol,indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DARAPRIM

Products Affected

- Daraprim

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient's immune status
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis

DAURISMO

Products Affected

- Daurismo oral tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medications that will be used in combination, comorbidities
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML - approve if Daurismo will be used in combination with cytarabine AND the patient meets i. OR ii: i. patient is using Daurismo for treatment induction and is greater than or equal to 75 years old or the patient has comorbidities that preclude the use of intensive induction chemotherapy according to the prescribing physician, OR ii. patient is continuing Daurismo as post-remission therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients continuing Daurismo as post-remission therapy

DESOXYN

Products Affected

- Desoxyn
- methamphetamine

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DOPTELET

Products Affected

- Doptelet (10 tab pack)
- Doptelet (15 tab pack)
- Doptelet (30 tab pack)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Thrombo w/chronic liver disease-5 days, chronic ITP-3 years
Other Criteria	Thrombocytopenia with chronic liver disease-Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy. Chronic ITP-approve if the patient has tried one other therapy or if the patient has undergone splenectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	asthma/AD-12 years of age and older. Chronic Rhinosinusitis-18 years of age and older
Prescriber Restrictions	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist
Coverage Duration	AD-Initial-16 weeks, Cont-1 year, asthma/Rhinosinusitis-initial-6 months, cont 1 year
Other Criteria	Atopic Dermatitis-Initial-meets both a and b: a.has used at least one medium, medium-high, high, and/or super-high-potency prescription topical corticosteroid OR has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment AND b.Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician.Continuation-Approve if the pt has responded to Dupixent therapy as determined by the prescribing physician. Asthma-Initial-approve if pt meets the following criteria (i, ii, and iii):i.Pt meets ONE of the following criteria (a or b):a)has a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received combination therapy with BOTH of the following (a and b): a)An inhaled corticosteroid (ICS) AND b)At least one additional asthma controller/maintenance medication (NOTE:An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS. Use of a combination

PA Criteria	Criteria Details
	inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a and b) AND iii.asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by ONE of the following (a, b, c, d or e): a)experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b)experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year OR c)has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d)has an FEV1/forced vital capacity (FVC) less than 0.80 OR e)The patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-Approve if meets the following criteria (i and ii): i.continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler AND ii.has responded to Dupixent therapy as determined by the prescribing physician. Chronic rhinosinusitis with Nasal Polyposis-Initial-pt is currently receiving therapy with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets ONE of the following (a or b): a)has received treatment with a systemic corticosteroid within the previous 2 years or has a contraindication to systemic corticosteroid therapy OR b)has had prior surgery for nasal polyps. Continuation-approve if the pt continues to receive therapy with an intranasal corticosteroid AND pt has responded to Dupixent therapy as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMFLAZA

Products Affected

- Emflaza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prescriber specialty
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD) and/or neuromuscular disorders
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMGALITY

Products Affected

- Emgality Pen
- Emgality Syringe subcutaneous syringe 120 mg/mL, 300 mg/3 mL (100 mg/mL x 3)

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Aimovig or Ajovy
Required Medical Information	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Migraine headache prevention-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. Episodic cluster headache treatment-approve if the patient has between one headache every other day and eight headaches per day.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel Mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous syringe
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist.PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist. Uveitis, prescribed by or in consultation with an ophthalmologist.
Coverage Duration	FDA approved indications - 3 months initial, 3 years cont, others 12 months.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first)

PA Criteria	Criteria Details
	OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic coricosteroid, immunosuppressives, Humira or an infliximab product.RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD, Uveitis Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Graft versus host disease (GVHD), Behcet's disease, Uveitis

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prescriber specialty
Age Restrictions	Greater than or equal to 5 years of age
Prescriber Restrictions	Prescribed by, or in consultation with, a physician who specializes in sickle cell disease (e.g., a hematologist)
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Patients 2 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EPOETIN ALFA

Products Affected

- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL
- Retacrit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	CRF anemia in patients on and not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Anemia w/myelosuppressive = 4 mos.Transfus=1 mo.Other=6mo. HIV + zidovudine = 4 mo
Other Criteria	For all covered uses, if the request is for Epogen, then the patient is required to try Procrit or Retacrit first.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndrome (MDS)

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	BCC (La or Met) - must not have had disease progression while on Odomzo.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ESBRIET

Products Affected

- Esbriet oral capsule
- Esbriet oral tablet 267 mg, 801 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with nintedanib
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	1 year
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVEKEO

Products Affected

- amphetamine sulfate
- Evekeo
- Evekeo ODT

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EVENITY

Products Affected

- Evenity subcutaneous syringe 210mg/2.34mL (105mg/1.17mLx2)

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (e.g., oral or IV bisphosphonates, Prolia, Forteo, Tymlos, calcitonin nasal spray) except calcium and Vitamin D
Required Medical Information	Diagnosis, medications that have been tried in the past, other medications that will be used in combination
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months of therapy per course of treatment.
Other Criteria	Treatment of postmenopausal osteoporosis, must meet ONE of the following-1. T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, or total hip, 2. has had osteoporotic fracture or fragility fracture, 3. had a T-score (current or at any time in the past) between -1.0 and -2.5 at the lumbar spine, femoral neck, or total hip and the physician determines the patient is at high risk for fracture AND patient has had had an inadequate response to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescribing physician (e.g., ongoing and significant loss of bone mineral density (BMD), lack of BMD increase), or had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy, or experienced intolerability to an oral bisphosphonate (e.g., severe GI-related adverse effects) OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition in which IV bisphosphonate therapy may be warranted (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid) OR patient has severe renal impairment (creatinine clearance less than 35 mL/min),

PA Criteria	Criteria Details
	chronic kidney disease or has had an osteoporotic fracture or a fragility fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EXJADE/JADENU

Products Affected

- deferasirox
- Exjade
- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- Fasenra

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody
Required Medical Information	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.
Other Criteria	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND meet both of the following criteria: 1) Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, or Theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following: a) patient experienced one or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS for at least 3 consecutive months. Continuation - The patient has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased

PA Criteria	Criteria Details
	asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to receive therapy with an inhaled corticosteroid.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FERRIPROX

Products Affected

- Ferriprox oral solution
- Ferriprox oral tablet 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 2,500 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FIRAZYR

Products Affected

- Firazyr
- icatibant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant-the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures (initial therapy)
Required Medical Information	Diagnosis, seizure history, lab and test results
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
Coverage Duration	Initial-3 months, Cont-1 year
Other Criteria	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FLECTOR

Products Affected

- diclofenac epolamine
- Flector

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Patients must try a generic oral NSAID or generic diclofenac 1% gel.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FORTEO

Products Affected

- Forteo

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 2 years of therapy over a patient's lifetime
Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has

PA Criteria	Criteria Details
	CKD or has had an osteoporotic fracture or fragility fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FULPHILA

Products Affected

- Fulphila

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Cancer pts receiving chemo-6 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if - the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	16 years and older
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease
Coverage Duration	3 years
Other Criteria	Approve if the patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	1 year and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
Coverage Duration	1 year
Other Criteria	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced at least a 20 percent decrease from baseline in the weekly volume of parenteral nutrition.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILENYA

Products Affected

- Gilenya oral capsule 0.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For NSCLC - EGFR exon deletions or mutations or if NSCLC is squamous cell type
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of metastatic non small cell lung cancer (NSCLC) must be used in tumors with non-resistant EGFR mutation positive NSCLC as detected by an approved test. NSCLC metastatic squamous cell must have disease progression with first line treatment with platinum based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Products Affected

- Adlyxin subcutaneous pen injector 10 mcg/0.2 mL- 20 mcg/0.2 mL, 20 mcg/0.2 mL
- Bydureon BCise
- Bydureon subcutaneous pen injector
- Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL
- Ozempic subcutaneous pen injector 0.25 mg or 0.5 mg(2 mg/1.5 mL), 1 mg/dose (2 mg/1.5 mL)
- Trulicity
- Victoza 3-Pak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GOCOVRI

Products Affected

- Gocovri oral capsule,extended release 24hr 137 mg, 68.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous medications tried, concurrent medications
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial and continuation).
Coverage Duration	Initial-3 months. Cont-1 year.
Other Criteria	Initial therapy - approve if the following criteria are met: 1) patient is currently receiving levodopa-based therapy (e.g., carbidopa/levodopa) AND, 2) patient has tried immediate-release amantadine (capsules, tablets, or oral solution) and derived benefit from the immediate-release formulation but had intolerable adverse events or the patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber. Cont. therapy - approve if 1) the patient is currently receiving levodopa-based therapy (e.g., carbidopa/levodopa) AND 2) patient has tried immediate-release amantadine (capsules, tablets, or oral solution) and derived benefit from the immediate-release formulation but had intolerable adverse events or the patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber, and 3) has had a response to therapy (e.g., decrease in dyskinesia), as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

Products Affected

- Eligard
- Eligard (3 month)
- Eligard (4 month)
- Eligard (6 month)
- leuprolide subcutaneous kit
- Lupaneta Pack (1 month)
- Lupaneta Pack (3 month)
- Lupron Depot
- Lupron Depot (3 month)
- Lupron Depot (4 month)
- Lupron Depot (6 Month)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	For abnormal uterine bleeding,uterine leiomyomata 6 mo.All other=12 mo
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors

GRALISE/HORIZANT/LYRICA CR

Products Affected

- Gralise 30-Day Starter Pack
- Gralise oral tablet extended release 24 hr 300 mg, 600 mg
- Horizant oral tablet extended release 300 mg, 600 mg
- Lyrica CR oral tablet extended release 24 hr 165 mg, 330 mg, 82.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer patient receiving chemo-Prescribed by or in consultation with an oncologist, infectious disease specialist, or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist or physician that specializes in transplantation.
Coverage Duration	PBPC-1 month, All others-6 months
Other Criteria	Cancer patients receiving Myelosuppressive Chemotherapy-Must meet ONE of the following - 1. be receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen) 2. be receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (e.g., at least 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, HIV infection) 3. have had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a CSF (e.g., filgrastim products, pegfilgrastim products, or Leukine) and a reduced dose or frequency of chemotherapy may compromise treatment OR 4. has received chemotherapy has febrile neutropenia and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescribing physician (e.g., sepsis syndrome, older than 65 years, severe neutropenia - ANC less than 100 cells/mm3, neutropenia expected to be

PA Criteria	Criteria Details
	more than 10 days in duration, invasive fungal infection, other clinically documented infections, or prior episode of febrile neutropenia).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients undergoing peripheral blood progenitor cell (PBPC) Collection and Therapy.

GROWTH HORMONES

Products Affected

- Genotropin
- Genotropin MiniQuick
- Humatrope
- Norditropin FlexPro
- Nutropin AQ Nuspin
- Omnitrope
- Saizen
- Saizen saizenprep
- Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg
- Zomacton
- Zorbtive

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	HIV-1.wasting/cachexia due to malabsorption, opportunistic infx, depression and other causes which have been addressed prior to starting tx 2.on antiretroviral or HAART or more than 30 days and will cont throughout Serostim tx 3.not being used for alternations in body fat distribution (abdom girth, liopdystrophy, buffalo hump, excess abdm fat), AND 4.unintentional wt loss greater than 10 percent from baseline, wt less than 90 percent of lower limit of IBW, or BMI less than or equal to 20 kg/m2.Cont-must be off therapy for 1 month.GHD in Child/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal ref range of the testing lab OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def], or prolactin).3. congenital hypopituitarism and has 1 GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the pt has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy

PA Criteria	Criteria Details
Age Restrictions	ISS 5 y/o or older, SGA 2 y/o or older, SBS and HIV wasting/cachexia 18 y/o or older
Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
Coverage Duration	ISS - 6 mos initial, 12 months cont tx, SBS - 1 month, HIV 6 months, others 12 mos
Other Criteria	GHD initial in adults and adolescents 1. endocrine must certify not prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalmic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or SAH, AND 3. meets one of the following - A. childhood onset has known mutations, embryonic lesions, congenital defects or irreversible structural hypothalmic pituitary lesion/damage, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, age and gender adjusted IGF1 below the lower limits of the normal reference range, AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI less than or equal to 25) or less than or equal to 1 mcg/L (BMI is greater than 25), for transitional adults glucagon peak less than or equal to 3 (BMI is less than 25) or less than or equal to 3 if BMI is greater than or equal to 25 and must also have a second GH stim test with low results, if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, Macrilen peak less than 2.8 ng/ml if BMI is less than or equal to 40 (adults only) AND if a transitional adoles must be off tx for at least one month before retesting. Cont tx - endocrine must certify not prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and ht velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline ht less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, ht less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for

PA Criteria	Criteria Details
	age/gender and born SGA (birth wt/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy. Cont Tx for CKD, Noonan, PW in child/adolescent, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support.Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support. If requesting Genotropin, Humatrope, Nutropin, Saizen or Zomacton must have tried Norditropin or Omnitrope prior to approval.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HARVONI

Products Affected

- Harvoni oral tablet 90-400 mg

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	N/A
Age Restrictions	12 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	patient is totally blind with no perception of light
Age Restrictions	18 years or older
Prescriber Restrictions	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont - Approve if pt has achieved adequate results with Hetlioz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Products Affected

- Ativan oral tablet 0.5 mg, 1 mg, 2 mg
- clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg
- diazepam oral concentrate
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet
- lorazepam oral concentrate
- lorazepam oral tablet 0.5 mg, 1 mg, 2 mg
- Tranxene T-Tab oral tablet 7.5 mg
- Valium

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = 12 months.
Other Criteria	All medically accepted indications other than insomnia, authorize use. Insomnia, may approve lorazepam if the patient has had a trial with two of the following: ramelteon, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BENZTROPINE

Products Affected

- benztropine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - CYCLOBENZAPRINE

Products Affected

- cyclobenzaprine oral tablet
- Fexmid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- hydroxyzine HCl oral tablet
- promethazine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For promethazine, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, aprepitant) for the current condition. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - PHENOBARBITAL

Products Affected

- phenobarbital

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for use in sedation/insomnia.
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS- ESTROGENS

Products Affected

- Activella oral tablet 1-0.5 mg
- Alora
- Amabelz
- Angeliq
- Bijuva
- Climara
- Climara Pro
- CombiPatch
- Divigel transdermal gel in packet 1 mg/gram (0.1 %)
- Dotti
- Elestrin
- Estrace oral
- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet
- Evamist
- Femhrt Low Dose
- Fyavolv
- Jinteli
- Lopreeza oral tablet 1-0.5 mg
- Menest oral tablet 0.3 mg, 0.625 mg, 1.25 mg
- Menostar
- Mimvey
- Mimvey Lo
- Minivelle
- norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg
- Prefest
- Premphase
- Prempro
- Vivelle-Dot

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged 65 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	For the treatment of Vulvar Vaginal Atrophy, approve if the patient has had a trial of one of the following for vulvar vaginal atrophy (brand or generic): Estradiol Vaginal Cream, Premarin Vaginal Cream, Vagifem, Imvexxy, Estring, Femring, or estradiol valerate. For prophylaxis of Postmenopausal Osteoporosis, approve if the patient has had a trial of one of the following (brand or generic): alendronate, ibandronate, risidronate or Raloxifene. For

PA Criteria	Criteria Details
	the treatment of Vasomotor Symptoms of Menopause, approve if the patient has tried one of the following products: Femring, Estradiol valerate or depo-estradiol. The physician has assessed risk versus benefit in using this High Risk medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- Humira Pediatric Crohns Start subcutaneous syringe kit 40 mg/0.8 mL, 40 mg/0.8 mL (6 pack)
- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 10 mg/0.2 mL, 20 mg/0.4 mL, 40 mg/0.8 mL
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS
- HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML
- Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), adults.
Prescriber Restrictions	RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	initial 3 mo, cont tx 3 years.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has

PA Criteria	Criteria Details
	tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) for 2 months or was intolerant to one of these agents, or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced (metastatic) hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer for patients who have not had disease progression while on Ibrance, Kisqali or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used in combination with anastrozole, exemestane, or letrozole 2, pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonists, or has had surgical bilateral oophorectomy, or ovarian irradiation AND meets one of the following conditions: Ibrance will be used in combination with anastrozole, exemestane, or letrozole Ibrance will be used in combination with Faslodex 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH agonist AND Ibrance with be used in combination with anastrozole, exemestane or letrozole or Ibrance will be used in combination with Faslodex 4. Pt is postmenopausal and Ibrance will be used in combination with Faslodex
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Liposarcoma

ICLUSIG

Products Affected

- Iclusig oral tablet 15 mg, 45 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	CML/ALL - Adults
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-posistive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	IDH2-mutation status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ILUMYA

Products Affected

- Ilumya

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	Initial therapy - 3 months. Continuation therapy - 3 years
Other Criteria	Initial Therapy - Approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. Continuation Therapy - Patient must have responded, as determined by the prescriber
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IMATINIB

Products Affected

- Gleevec oral tablet 100 mg, 400 mg
- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years.
Other Criteria	For ALL/CML, new patient must have Ph-positive for approval of imatinib. AIDS related Kaposi's Sarcoma-approve if the patient has tried one prior regimen AND has relapsed or refractory disease. For all diagnoses-generic must be tried before brand. Approve brand Gleevec if the patient has tried generic imatinib mesylate tablets AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, AIDS Related Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.

IMBRUVICA

Products Affected

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	GVHD-1 year, all others-3 years
Other Criteria	Marginal Zone Lymphoma - Approve if the patient has tried Rituxan (rituximab for intravenous infusion) or according to the prescribing physician, Rituxan is contraindicated for use in this patient. GVHD-Approve if the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib). Diffuse large B-cell lymphoma-approve if the patient is using Imbruvica as second-line or subsequent therapy according to the prescribing physician.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Relapsed or refractory Central Nervous System Lymphoma (Primary). Plus relapsed or refractory Hairy Cell Leukemia. Plus Diffuse Large B-Cell Lymphoma (e.g., follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma, primary DLBCL of the central nervous system).

INBRIJA

Products Affected

- Inbrija inhalation capsule, w/inhalation device

PA Criteria	Criteria Details
Exclusion Criteria	Asthma, COPD, other chronic underlying lung disease
Required Medical Information	Diagnosis, medications that will be used in combination
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Approve if the patient is currently taking carbidopa-levodopa
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INGREZZA

Products Affected

- Ingrezza
- Ingrezza Initiation Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or psychiatrist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INJECTABLE TESTOSTERONE PRODUCTS

Products Affected

- Aveed
- Depo-Testosterone
- testosterone cypionate
- testosterone enanthate
- Xyosted

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab results
Age Restrictions	Delayed puberty or induction of puberty in males-14 years and older
Prescriber Restrictions	N/A
Coverage Duration	Delayed puberty or induction of puberty in males-6 months, all others-12 months
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. Delayed puberty or induction of puberty in males - Approve testosterone cypionate or testosterone enanthate. Palliative treatment of inoperable metastatic breast cancer in females. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

INLYTA

Products Affected

- Inlyta oral tablet 1 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate-2 or high-risk disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IVIG

Products Affected

- Flebogamma DIF intravenous solution 10 %
- Gammagard Liquid
- Gammagard S-D (IgA < 1 mcg/mL)
- Gammaked injection solution 1 gram/10 mL (10 %)
- Gammaplex
- Gammaplex (with sorbitol)
- Gamunex-C injection solution 1 gram/10 mL (10 %)
- Octagam
- Panzyga
- Privigen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kynamro, Praluent, or Repatha.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	12 months
Other Criteria	Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha) OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) Patient has tried Repatha and had an inadequate response according to the prescribing physician OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

JYNARQUE

Products Affected

- Jynarque

PA Criteria	Criteria Details
Exclusion Criteria	Patient is currently receiving Samsca (tolvaptan tablets) . Patients with Stage 5 CKD
Required Medical Information	Diagnosis, renal function
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist
Coverage Duration	1 year (initial and continuation)
Other Criteria	Approve if the patient has rapidly-progressing autosomal dominant polycystic kidney disease (ADPKD) (e.g., reduced or declining renal function, high or increasing total kidney volume [height adjusted]),according to the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi or Symdeko
Required Medical Information	N/A
Age Restrictions	6 months of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	1 year
Other Criteria	CF - must have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G A, 3272-26A G, 3849+10kbC T, 711+3A G, E831X OR R117H AND must NOT be Homozygous for the F508del Mutation in the CFTR Gene or have unknown CFTR gene mutations.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of condition, prior medications tried and results, potassium levels
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial 2 months, cont 12 months.
Other Criteria	HypoPP and Related Variants initial must meet all - 1. HypoPP has been confirmed by one of the following - serum potassium concentration of less than 3.5 mEq/L during a paralytic attack, family history of the condition, or a genetically confirmed skeletal muscle calcium or sodium channel mutation, 2. had improvements in paralysis attack symptoms with potassium intake, and 3. tried oral acetazolamide therapy, and 4. according to the prescribing physician, acetazolamide therapy did not worsen the paralytic attack frequency or severity in the patient, and 5. the prescribing physician has excluded other reasons for acquired hypokalemia (e.g., renal, adrenal, thyroid dysfunction, renal tubular acidosis, diuretic and laxative abuse). HyperPP and Related Variants initial must meet all - 1. HyperPP has been confirmed by one of the following - an increase from baseline in serum potassium concentration of greater than or equal to 1.5 mEq/L during a paralytic attack, serum potassium concentration during a paralytic attack of greater than 5.0 mEq/L, a family history of the condition, or genetically confirmed skeletal muscle sodium channel mutation, 2. prescribing physician has excluded other reasons for acquired hyperkalemia (e.g., drug abuse, renal and adrenal dysfunction), 3. tried oral acetazolamide therapy, 4. according to the prescribing physician, acetazolamide therapy did not worsen the paralytic attack frequency or severity in the patient. Cont tx HypoPP and HyperPP - patient has

PA Criteria	Criteria Details
	responded to Keveyis (e.g., decrease in the frequency or severity of paralytic attacks) as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEVZARA

Products Affected

- Kevzara subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Initial-3 months, cont-3 years
Other Criteria	RA initial - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC) , or Xeljanz/XR (Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the 'try TWO' requirement: Cimzia, an infliximab product, golimumab SC/IV, Actemra, Rituxan or Kineret) OR if, according to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. Cont tx - pt must have had a response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA and Still's disease, prescribed by or in consultation with a rheumatologist. CAPS (Neonatal-Onset Multisystem Inflammatory Disease or Chronic Infantile Neurological Cutaneous and Articular [CINCA] syndrome), prescribed by or in consultation with a pediatrician, rheumatologist, geneticist, or dermatologist.
Coverage Duration	RA/CAPS initial 3 mos, cont 3 years. Stills 12 mos
Other Criteria	RA initial. Approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC), or Xeljanz/XR. [Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the 'try TWO' requirement: Actemra, Cimzia, infliximab, Kevzara, golimumab IV/SC.] RA/CAPS cont tx - approve if the patient had responded to therapy as determined by the prescriber. Still's Disease, approve if patient has tried a corticosteroid and has had an inadequate response to 1 conventional synthetic DMARD (eg, methotrexate) for at least 2 months or was intolerant to this therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Still's disease (SD). Juvenile Rheumatoid Arthritis.

KISQALI

Products Affected

- Kisqali
- Kisqali Femara Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer in patients who have not had disease progression while on Kisqali, Ibrance or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH agonist AND Kisqali with be used in combination with anastrozole, exemestane or letrozole. 4. Patient is postmenopausal, pre/perimenopausal or a man, and Kisqali (not Co-Pack) will be used in combination with Faslodex 5. Patient is pre/perimenopausal and Kisqali (not Co-Pack) will be used in combination with tamoxifen as first line therapy. If the request is for Kisqali Femara, patients do not need to use in combination with anastrozole, exemestane, or letrozole.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Men with breast cancer

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
Coverage Duration	Endogenous Cushing's Synd-1 year. Patients awaiting surgery or response after radiotherapy-4 months
Other Criteria	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Endogenous Cushing's Syndrome, awaiting surgery, Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Palynziq
Required Medical Information	Diagnosis, Phe concentration
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
Coverage Duration	Initial-12 weeks, Continuation-1 year
Other Criteria	Initial - approve. Continuation - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20% or greater reduction in blood Phe concentration from baseline.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LEDIPASVIR/SOFOSBUVIR

Products Affected

- ledipasvir-sofosbuvir

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	N/A
Age Restrictions	12 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. And, patients with genotype 1, 4, 5 and 6 must have a trial with Harvoni or Epclusa prior to approval of ledipasvir-sofosbuvir, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	DTC - must be refractory to radioactive iodine treatment for approval. RCC (clear cell or non-clear cell) - approve if the pt meets ALL of the following criteria: 1) pt has relapsed or stage IV disease, 2) if disease is predominant clear-cell histology then the pt has tried one antiangiogenic therapy (eg, Inlyta, Votrient, Sutent, Cabometyx) AND 3) Lenvima will be used in combination with everolimus (Afinitor). MTC-approve if the patient has tried Caprelsa or Cometriq. Anaplastic thyroid cancer-approve if the disease does not have a curative option.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Medullary Thyroid Carcinoma (MTC) and anaplastic thyroid carcinoma.

LETAIRIS/TRACLEER

Products Affected

- ambrisentan
- bosentan
- Letairis
- Tracleer

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
Age Restrictions	N/A
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist.CTEPH-prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 1 year.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)

LEUKINE

Products Affected

- Leukine injection recon soln

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	AML if prescribed by or in consultation with an oncologist or hematologist, PBPC - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation, Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome
Coverage Duration	Radiation Syndrome - 1 mo, AML-6 months, PBPC-14 days, Bone marrow transplant-6 months
Other Criteria	Peripheral Blood Progenitor Cell (PBPC) Collection-patients with cancer or patients with cancer who have received therapy with PBPC (Autologous).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LIDOCAINE PATCH

Products Affected

- lidocaine topical adhesive patch,medicated
- Lidoderm
- ZTlido

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Chronic back pain-approve if the patient has tried two pharmacologic therapies with each one from a different class of medication used to treat low back pain (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], muscle relaxants, celecoxib, duloxetine, gabapentin).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain, chronic back pain

LONG ACTING OPIOIDS

Products Affected

- Belbuca
- buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour
- buprenorphine transdermal patch weekly 7.5 mcg/hour
- Butrans
- ConZip
- Dolophine oral tablet 10 mg, 5 mg
- Embeda oral capsule,oral only,ext.rel pell
- hydromorphone oral tablet extended release 24 hr
- Hysingla ER
- Kadian oral capsule,extend.release pellets 100 mg, 20 mg, 200 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg
- methadone oral solution 10 mg/5 mL, 5 mg/5 mL
- methadone oral tablet 10 mg, 5 mg
- MorphaBond ER
- morphine oral capsule, ER multiphase 24 hr
- morphine oral capsule,extend.release pellets
- morphine oral tablet extended release
- MS Contin
- Nucynta ER
- oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
- OxyContin oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
- oxymorphone oral tablet extended release 12 hr
- tramadol oral capsule,ER biphase 24 hr 17-83
- tramadol oral capsule,ER biphase 24 hr 25-75 100 mg, 200 mg
- tramadol oral tablet extended release 24 hr
- tramadol oral tablet, ER multiphase 24 hr
- Xtampza ER
- ZOHYDRO ER CAPSULE, ORAL ONLY, ER 12HR

PA Criteria	Criteria Details
Exclusion Criteria	Acute (ie, non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid

PA Criteria	Criteria Details
	treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastric or Gastroesophageal Junction Adenocarcinoma, Metastatic-approve if the patient has been previously treated with at least two chemotherapy regimens for gastric or gastroesophageal junction adenocarcinoma.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LORBRENA

Products Affected

- Lorbrena oral tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, ALK status, previous therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC and meets one of the following: a) patient has disease progression on Xalkori (crizotinib capsules) and at least one other ALK inhibitor (e.g., Zykadia [ceritinib capsules], Alecensa [alectinib capsules], Alunbrig [brigatinib tablets]), or b) patient has disease progression on Alecensa (alectinib capsules) as the first ALK inhibitor therapy, or c) patient has disease progression on Zykadia (ceritinib capsules) as the first ALK inhibitor therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LUCEMYRA

Products Affected

- Lucemyra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 14 days
Other Criteria	Opioid withdrawal symptoms-patient is using requested medication to facilitate abrupt opioid discontinuation
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Ovarian Cancer - Treatment-initial-Approve if the patient meets the following criteria (i and ii): i. The patient has a germline BRCA-mutation as confirmed by an approved test AND per product labeling the patient has progressed on three or more prior lines of chemotherapy. Continuation-approve if the patient has a BRCA mutation (germline) as confirmed by an approved test. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer-Maintenance Therapy-Approve if the patient meets one of the following criteria (A or B): A) The patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. The patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B) The patient meets both of the following criteria (i and ii): i. The patient has recurrent disease AND ii. The patient is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). Breast Cancer-Approve if the patient meets the following criteria (A, B, C, and D)-A. The patient has metastatic, germline BRCA mutation-positive breast cancer AND B. The patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C. The patient meets ONE

PA Criteria	Criteria Details
	of the following criteria (i or ii)- i. The patient meets BOTH of the following criteria (a and b)-a) The patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b) The patient meets ONE of the following criteria (1 or 2)-1-The patient has been treated with prior endocrine therapy OR-2 The patient is considered inappropriate for endocrine therapy OR ii. Patient has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND D. The patient has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MAVENCLAD

Products Affected

- Mavenclad (10 tablet pack)
- Mavenclad (4 tablet pack)
- Mavenclad (5 tablet pack)
- Mavenclad (6 tablet pack)
- Mavenclad (7 tablet pack)
- Mavenclad (8 tablet pack)
- Mavenclad (9 tablet pack)

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis
Required Medical Information	Diagnosis, other medications that will be used in combination
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has tried at least one other disease-modifying therapy for multiple sclerosis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	12 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. And, patients with genotype 1, 4, 5 and 6 must have a trial with Harvoni or Epclusa prior to approval of Mavyret, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines. Genotype 2 and 3 must have an Epclusa trial prior to approval of Mavyret, unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines. Patients who are greater than or equal to 12 but less than 18 are not required to try Epclusa prior to approval of Mavyret.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

MAYZENT

Products Affected

- Mayzent oral tablet 0.25 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEGACE

Products Affected

- megestrol oral suspension 400 mg/10 mL (40 mg/mL), 625 mg/5 mL
- megestrol oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKINIST

Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery.For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafinlar, unless intolerant AND the patient has BRAF V600-positive disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEMANTINE

Products Affected

- memantine oral capsule,sprinkle,ER 24hr
- memantine oral solution
- memantine oral tablet
- memantine oral tablets,dose pack
- Namenda oral tablet
- Namenda Titration Pak
- Namenda XR
- Namzaric

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Indication for which memantine is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with mild to moderate vascular dementia.

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 8 to 14 days after starting Mulpleta therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND patient is responding to Natapara therapy, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Stage of cancer, HER2 status, previous or current medications tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months
Other Criteria	Breast cancer - approve if the patient meets all of the following criteria: 1. Patient has early stage disease, AND 2. Patient has HER2-positive breast cancer, AND 3. Patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NEULASTA

Products Affected

- Neulasta subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation. Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome.
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC/Radiation Syndrome-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients undergoing PBPC collection and therapy

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 months.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-3 mo.All others=12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver or renal dysfunction, poor performance status, HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be

PA Criteria	Criteria Details
	greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve if disease is FLT3-ITD mutation positive as detected by an approved test. Renal cell carcinoma (RCC)-approve if the patient has relapsed or Stage IV clear cell histology and the patient has tried at least one prior systemic therapy (e.g., Inlyta, Votrient, Sutent Cabometyx). Ovarian, fallopian tube, primary peritoneal cancer-approve if the patient has platinum resistant disease and Nexavar is used in combination with topotecan.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Osteosarcoma, angiosarcoma, desmoids tumors (aggressive fibromatosis), gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma, ovarian, fallopian tube, primary peritoneal cancer

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone AND pt had received at least ONE previous therapy for multiple myeloma. Systemic light chain amyloidosis-approve if the patient has tried at least one other regimen for this condition.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with systemic light chain amyloidosis

NITYR/ORFADIN

Products Affected

- Nityr
- Orfadin

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Orfadin and Nityr
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Hereditary Tyrosinemia, Type 1-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated serum levels of alpha-fetoprotein (AFP) and succinylacetone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NIVESTYM

Products Affected

- Nivestym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-3 mo.All other=12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia

PA Criteria	Criteria Details
	expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).

NOCDURNA

Products Affected

- Nocdurna (men)
- Nocdurna (women)

PA Criteria	Criteria Details
Exclusion Criteria	Currently receiving loop diuretics, systemic or inhaled glucocorticoids OR renal impairment with an estimated glomerular filtration rate less than 50 mL/min/1.73 per meter squared OR heart failure OR polydipsia OR known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion
Required Medical Information	Diagnosis, lab values, other medications that will be used in combination
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a urologist, a geriatrician, or an endocrinologist
Coverage Duration	12 months
Other Criteria	Prior to desmopressin therapy, the patient awakens at least two times per night to void AND the patient has serum sodium concentrations within the normal range (135 to 145 mmol/L) AND the diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection before treatment initiation and the patient meets one of the following (i or ii): i. The nocturnal urine volume exceeds 20% of the total 24-hour urine volume in patients less than 65 years of age OR ii. The nocturnal urine volume exceeds 33% of the total 24-hour urine volume in patients greater than or equal to 65 years of age.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NOCTIVA

Products Affected

- Noctiva

PA Criteria	Criteria Details
Exclusion Criteria	Currently receiving loop diuretics, systemic or inhaled glucocorticoids OR renal impairment with an estimated glomerular filtration rate less than 50 mL/min/1.73 per meter squared OR New York Heart Association (NYHA) Class II to IV congestive heart failure (CHF) OR polydipsia OR known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion
Required Medical Information	Diagnosis, lab values, other medications that will be used in combination
Age Restrictions	50 years or older
Prescriber Restrictions	Prescribed by or in consultation with a urologist, a geriatrician, or an endocrinologist
Coverage Duration	12 months
Other Criteria	Prior to desmopressin therapy, the patient awakens at least two times per night to void AND the patient has serum sodium concentrations within the normal range (135 to 145 mmol/L) AND the diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection before treatment initiation and the patient meets one of the following (i or ii): i. The nocturnal urine volume exceeds 20% of the total 24-hour urine volume in patients less than 65 years of age OR ii. The nocturnal urine volume exceeds 33% of the total 24-hour urine volume in patients greater than or equal to 65 years of age.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	12 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
Required Medical Information	N/A
Age Restrictions	Asthma-12 years of age and older. EGPA-18 years of age and older.
Prescriber Restrictions	Asthma-Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA-prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist.
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.
Other Criteria	Asthma initial - must have blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with any anti-interleukin (IL)-5 therapy) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following A. inhaled LABA, B. inhaled long-acting muscarinic antagonist, C. Leukotriene receptor antagonist, or D. Theophylline. Patient's asthma continues to be uncontrolled, or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy (e.g., Cinqair, Fasenra, Nucala) used concomitantly with an ICS for at least 3 consecutive months. Continuation - The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma

PA Criteria	Criteria Details
	exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with an inhaled corticosteroid. EGPA initial-patient has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL)-5 therapy (e.g., Nucala, Cinqair, Fasenra). Continuation-The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., reduced rate of relapse, corticosteroid dose reduction, reduced eosinophil levels).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUPLAZID

Products Affected

- Nuplazid oral capsule
- Nuplazid oral tablet 10 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUVIGIL/PROVIGIL

Products Affected

- armodafinil
- modafinil
- Nuvigil
- Provigil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be greater than or equal to 17 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults (modafanil only) if the patient is concurrently receiving other medication therapy for depression.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Excessive daytime sleepiness (EDS) due to myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial and continuation therapy)
Coverage Duration	6 months initial, 3 years cont.
Other Criteria	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	BCC - Must not have had disease progression while on Erivedge (vismodegib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Metastatic BCC

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with pirfenidone
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	1 year
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OLUMIANT

Products Affected

- Olumiant

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other biologics, DMARDs, or other potent immunosuppressants
Required Medical Information	Diagnosis, previous medication use, concurrent medication
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist
Coverage Duration	Initial - 3 months, continuation - 3 years
Other Criteria	Initial therapy - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC), or Xeljanz/XR. [Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the 'try TWO' requirement: Actemra IV/SC, Cimzia, infliximab, Simponi golimumab IV/SC, Kevzara, Kineret, and Rituxan.] Continuation therapy - approve if the patient has had a response, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORALAIR

Products Affected

- Oralair sublingual tablet 300 indx reactivity

PA Criteria	Criteria Details
Exclusion Criteria	The patient is NOT currently receiving SC or SL allergen immunotherapy
Required Medical Information	Diagnosis
Age Restrictions	5 years through 65 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The diagnosis of grass pollen-induced AR must be confirmed by either 1. positive skin test response to a grass pollen from the Pooideae subfamily of grasses (this includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass), or 2. positive in vitro test (i.e., a blood test for allergen-specific IgE antibodies) for a grass in the Pooideae subfamily of grasses. Therapy must be initiated 16 weeks prior to the expected onset of the grass pollen season or therapy is being dosed daily continuously for consecutive grass pollen seasons.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orencia
- Orencia ClickJect

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], approve. Cont tx - responded to therapy as per the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, results of right heart cath
Age Restrictions	N/A
Prescriber Restrictions	PAH must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). For initial Orenitram therapy, patient must have either A) tried TWO or is currently receiving TWO oral therapies for PAH from different categories (either alone or in combination) each for greater than or equal to 60 days - phosphodiesterase type 5 (PDE5) inhibitor (eg, sildenafil, Adcirca), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit] or Adempas OR B) is receiving or has received in the past one prostacyclin therapy (eg, Ventavis or epoprostenol injection).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- Orkambi oral granules in packet
- Orkambi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco or Symdeko.
Required Medical Information	N/A
Age Restrictions	2 years of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OSMOLEX

Products Affected

- Osmolex ER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Previous medications tried, concurrent medications
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial and continuation).
Coverage Duration	Initial-3 months. Cont-1 year.
Other Criteria	Initial therapy - approve if the following criteria are met: patient has tried immediate-release amantadine capsules, tablets, or oral solution and derived benefit but had intolerable adverse events as determined by the prescriber OR the patient could not achieve a high enough dosage to gain adequate benefit as determined by the prescriber. Continuation therapy - approve if the following criteria are met: patient has tried immediate-release amantadine capsules, tablets, or oral solution and derived benefit but had intolerable adverse events as determined by the prescriber OR the patient could not achieve a high enough dosage to gain adequate benefit as determined by the prescriber AND the patient has had a response to therapy as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous drugs tried
Age Restrictions	N/A
Prescriber Restrictions	PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist.
Coverage Duration	4 months initial, 3 years cont
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to 'step back' and try a conventional DMARD first). PsA/PP cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	2 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PALYNZIQ

Products Affected

- Palynziq subcutaneous syringe 10 mg/0.5 mL, 2.5 mg/0.5 mL, 20 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, phenylalanine concentrations
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year (initial and continuation)
Other Criteria	Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., prior treatment with Kuvan). Maintenance therapy - approve if the patient's blood phenylalanine concentration is less than or equal to 600 micromol/L OR the patient has achieved at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHENYLBUTYRATE

Products Affected

- Buphenyl
- Ravicti
- sodium phenylbutyrate

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Ravicti and Buphenyl
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
Other Criteria	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHEOCHROMOCYTOMA

Products Affected

- Demser
- Dibenzyline
- phenoxybenzamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior medication trials
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial therapy for phenoxybenzamine, initial and continuation therapy for Demser)
Coverage Duration	Authorization will be for 1 year
Other Criteria	If brand Dibenzyline is being requested, approve if the patient has tried and cannot take generic phenoxybenzamine due to a formulation difference in the inactive ingredients between the brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or a serious adverse reaction. If the requested drug is Demser for intial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). If the requested drug is Demser for continuation therapy, approve if the patient is currently receiving Demser or has received Demser in the past.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Products Affected

- Adcirca
- Alyq
- Revatio oral suspension for reconstitution
- Revatio oral tablet
- sildenafil (Pulmonary Arterial Hypertension) oral suspension for reconstitution 10 mg/mL
- sildenafil (Pulmonary Arterial Hypertension) oral tablet 20 mg
- tadalafil (Pulmonary Arterial Hypertension) oral tablet 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, right heart cath results
Age Restrictions	N/A
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension (Revatio, generics) require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIQRAY

Products Affected

- Piqray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast Cancer. Approve if the patient meets the following criteria (A, B, C, D, and E): A) The patient is a postmenopausal female or a male AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, Faslodex, tamoxifen, toremifene).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PLEGRIDY

Products Affected

- Plegridy subcutaneous pen injector 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL
- Plegridy subcutaneous syringe 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myelofibrosis, Systemic Light Chain Amyloidosis, AIDS-Related Kaposi Sarcoma, relapsed or refractory disease, Central Nervous System (CNS) Lymphoma, relapsed or refractory disease

PRALUENT

Products Affected

- Praluent Pen

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid or Kynamro.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Hyperlipidemia in patients with HeFH -approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD - approve if meets all of the following: has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical]), abaloparatide except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year
Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture. Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer,

PA Criteria	Criteria Details
	approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
Required Medical Information	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist. Thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease.
Coverage Duration	Chronic ITP - 3 years, others 12 months.
Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried ONE other therapy or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy. Aplastic anemia - has low platelet counts at baseline/pretreatment (e.g., less than 30,000 mm3) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REBIF

Products Affected

- Rebif (with albumin)
- Rebif Rebidose subcutaneous pen injector 22 mcg/0.5 mL, 44 mcg/0.5 mL, 8.8mcg/0.2mL-22 mcg/0.5mL (6)
- Rebif Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Diagnosis of MS includes the following patient types: patients with actual diagnosis of MS, patients who have experienced an MS attack, and patients who are at risk for developing MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	MS, clinically isolated syndrome

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid, Kynamro, or Praluent.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Approve for 3 years for ASCVD/HeFH/HoFH. Approve for 1 year for primary hyperlipidemia.
Other Criteria	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or

PA Criteria	Criteria Details
	higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if all of the following are met: 1) coronary artery calcium or calcification (CAC) score 300 Agatston units or higher, AND 2) tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens OR 2) Pt has tried one prior therapy or therapeutic regimen and cannot take Velcade according to the prescribing physician. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen. Myelofibrosis-approve if the pt has tried one other therapy. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried one other chemotherapy regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis. Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell.

RINVOQ

Products Affected

- Rinvoq ER

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	18 years and older
Prescriber Restrictions	RA, prescribed by or in consultation with a rheumatologist.
Coverage Duration	Authorization will be for 3 months initial, 3 years cont.
Other Criteria	RA initial-approve if the patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Continuation Therapy - Patient must have responded, as determined by the prescriber
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3years
Other Criteria	Ovarian, Fallopian Tube or Primary Peritoneal Cancer-treatment - Approve if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy. Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer-Approve if the patient has recurrent disease and patient is in complete or partial response after at least two lines of platinum-based chemotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RUZURGI

Products Affected

- Ruzurgi

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures (initial therapy)
Required Medical Information	Diagnosis, seizure history, lab and test results
Age Restrictions	Patients between the ages of 6 years old and less than 17 years old (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
Coverage Duration	Initial-3 months, Cont-1 year
Other Criteria	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Ruzurgi, according to the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For AML, FLT3 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML-approve if the patient is FLT3-mutation positive as detected by an approved test AND the patient is receiving Rydapt in one of the following settings (i, ii, iii, or iv)-i. Induction therapy in combination with cytarabine and daunorubicin OR ii. After standard-dose cytarabine induction/reinduction, along with cytarabine and daunorubicin OR iii. Post remission or consolidation therapy in combination with cytarabine OR iv. Maintenance therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Jynarque.
Required Medical Information	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 30 days
Other Criteria	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SILIQ

Products Affected

- Siliq

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Previous medication use
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	Initial therapy - 3 months, Continuation therapy - 3 years
Other Criteria	Initial therapy-Plaque Psoriasis-Approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SIMPONI

Products Affected

- Simponi

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/Ankylosing spondylistis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	AS approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA-approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia, Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. Ulcerative colitis - approve if the patient has had a trial with Humira. Cont tx - must have a response to therapy as according to prescriber
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- Skyrizi subcutaneous syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older (initial therapy)
Prescriber Restrictions	PP-Prescribed by or in consultation with a dermatologist (initial therapy)
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	Initial Therapy-The patient meets ONE of the following conditions (a or b): a) The patient has tried at least one traditional systemic agent for psoriasis (e.g., methotrexate [MTX], cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light [PUVA]) for at least 3 months, unless intolerant. NOTE: An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (e.g., an adalimumab product [Humira], a certolizumab pegol product [Cimzia], an etanercept product [Enbrel, Erelzi], an infliximab product [e.g., Remicade, Inflectra, Renflexis], Cosentyx [secukinumab SC injection], Ilumya [tildrakizumab SC injection], Siliq [brodalumab SC injection], Stelara [ustekinumab SC injection], Taltz [ixekizumab SC injection], or Tremfya [guselkumab SC injection]). These patients who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional systemic agent for psoriasis)b) The patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician.Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOFOSBUVIR/VELPATASVIR

Products Affected

- sofosbuvir-velpatasvir

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied according to AASLD guidelines. And, patients with genotype 1, 4, 5 and 6 must have a trial with Harvoni or Epclusa prior to approval of sofosbuvir-velpatasvir, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines. Genotype 2 and 3 must have an Epclusa trial prior to approval of sofosbuvir-velpatasvir, unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

SOLARAZE

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 6 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOVALDI

Products Affected

- Sovaldi oral tablet 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Genotype 1 and 4 -18 years or older, Genotype 2 and 3-12 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. And, patients with genotype 1 and 4 must have a trial with Harvoni or Epclusa prior to approval of Sovaldi, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines. Patients with Genotype 2 and 3 must have a trial of Epclusa prior to approval of Sovaldi, unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines. Patients with Genotype 2 or 3, who are greater than or equal to 12 but less than 18 are not required to try Epclusa prior to approval of Sovaldi.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

SPRYCEL

Products Affected

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - has D842V mutation AND previously tried Sutent and Gleevec.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	GIST, chondrosarcoma, chordoma

STELARA

Products Affected

- Stelara subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	Adults-PsA and CD. PP-12 years and older.
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist. CD-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	PP/PsA Init-3mo,CD load-approve 1 dose IV,CD post IV load-approve SC 3 mo,cont tx-approve SC 3 yr
Other Criteria	PP initial - approve Stelara SC. CD, initial therapy - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). For HCC, patient must have previously been treated with at least one tyrosine kinase inhibitor (e.g., Nexavar, Lenvima). Soft tissue sarcoma-approve if the patient has non-adipocytic extremity/superficial trunk, head/neck or retroperitoneal/intra-abdominal sarcoma OR pleomorphic rhabdomyosarcoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue Sarcoma

SUCRAID

Products Affected

- Sucraid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, genetic and lab test results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness due to Obstructive Sleep Apnea-Approve. Narcolepsy-Approve.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST), approve if the patient has tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy or radiation therapy. Renal Cell Carcinoma (RCC), clear cell or non-clear cell histology-approve if the patient is at high risk of recurrent clear cell RCC following nephrectomy and Sutent is used for adjuvant therapy or if the patient has relapsed or Stage IV disease. Neuroendocrine tumors of the pancreas-approve for advanced or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, meningioma, thymic carcinoma.

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	Patients with unknown CFTR gene mutations
Required Medical Information	Diagnosis, specific CFTR gene mutations
Age Restrictions	Six years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A G, S945L, S977F, F1052V, E831X, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G A, 3272-26A G, or 3849 + 10kbC T OR the patient has two copies of the F508del mutation
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SYMLIN

Products Affected

- SymlinPen 120
- SymlinPen 60

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SYPRINE

Products Affected

- Syprine
- trientine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medication history, pregnancy status, disease manifestations
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAFAMIDIS

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with Onpattro or Tegsedi.Concurrent use of Vyndaqel and Vyndamax.
Required Medical Information	Diagnosis, genetic tests and lab results
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
Coverage Duration	1 year
Other Criteria	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis-approve if the patient meets all of the following: patient has genetic testing to identify a transthyretin (TTR) mutation (e.g., Val122Ile mutation, Thr60Ala mutation) or wild-type amyloidosis AND diagnosis was confirmed by one of the following (i or ii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy) OR ii. Amyloid deposits are identified on cardiac biopsy AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Differentiated Thyroid Cancer

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	NSCLC - prior therapies and EGFR T790M mutation or EGFR exon 19 deletion or exon 21 (L858R) substitution
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on one of the EGFR tyrosine kinase inhibitors (e.g., Tarceva, Iressa, Vizimpro or Gilotrif) therapy OR Advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) substitution as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAKHZYRO

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other HAE Prophylactic Therapies (e.g., Cinryze, Haegarda)
Required Medical Information	Diagnosis, lab values
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders (initial and continuation).
Coverage Duration	1 year
Other Criteria	Prophylaxis, initial therapy-approve if the patient meets all of the following criteria: 1) patient has HAE due to C1 Inhibitor (C1-INH) deficiency (Type I or II), AND 2) patient has low levels of functional C1-INH protein (less than 60% of normal) at baseline, as defined by the laboratory reference values, AND 3) patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Prophylaxis, continuation therapy-approve if the patient meets all of the following criteria: 1) patient is currently receiving Takhzyro for HAE type I or II, AND 2) according to the prescribing physician, the patient has had a favorable clinical response to therapy (e.g., decrease in number of HAE acute attack frequency, decrease in HAE attack severity, decrease in duration of HAE attacks).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALTZ

Products Affected

- Taltz Autoinjector
- Taltz Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older
Prescriber Restrictions	PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Initial authorization will be for 3 months, 3 years continuation.
Other Criteria	Initial Therapy - Plaque Psoriasis-approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. PsA-Approve if the patient has tried TWO of the following: Enbrel, Humira, Stelara SC, Otezla, Orencia, Xeljanz/XR or Cosentyx. Continuation Therapy - approve if the patient has responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALZENNA

Products Affected

- Talzenna oral capsule 0.25 mg, 1 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRCA mutation status, HER2 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally-advanced or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive AND human epidermal growth factor receptor 2 (HER2) negative disease
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TARCEVA

Products Affected

- erlotinib oral tablet 100 mg, 150 mg, 25 mg
- Tarceva oral tablet 100 mg, 150 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic NSCLC, approve if the patient meets both of the following: 1. patient is EGFR mutation positive, AND 2. patient has EGFR exon 19 deletions OR exon 21 (L858R) substitution mutations as detected by an FDA-approved test. Advanced RCC, approve if the patient has non-clear cell histology.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Renal Cell Carcinoma and Bone Cancer-Chordoma.

TARGRETIN ORAL

Products Affected

- bexarotene
- Targretin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	Initial therapy- approve if the following criteria are met: Patient has tried ONE oral retinoid, methotrexate, or phototherapy. (NOTE: An exception to the requirement for a trial of an oral retinoid, methotrexate, or phototherapy can be made if the patient has already used one of the following: interferons, histone deacetylase [HDAC] inhibitors, Poteligeo or extracorporeal photopheresis. These patients are not required to step back and try an oral retinoid, methotrexate, or phototherapy) OR the patient has a type of CTCL (e.g., folliculotropic disease, advanced disease) that, according to the prescribing physician, requires treatment with oral bexarotene capsules. If brand Targretin is requested, the patient has tried and cannot take generic bexarotene capsules due to a formulation difference in the inactive ingredient(s) between the brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or a serious adverse reaction. Continuation therapy- approve if brand Targretin is requested, the patient has tried and cannot take generic bexarotene capsules due to a formulation difference in the inactive ingredient(s) between the brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or a serious adverse reaction.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

TARGRETIN TOPICAL

Products Affected

- Targretin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	Initial therapy-approve if the patient has tried a topical corticosteroid and topical imiquimod cream (Aldara, generics, Zyclara). (NOTE: An exception to the requirement for a trial of a topical corticosteroid and topical imiquimod cream can be made if the patient has already used one of the following: a skin-directed therapy, e.g., topical chemotherapy, topical retinoids, local radiation, phototherapy [UVB, NB-UVB, PUVA], TSEBT, or a systemic therapy, e.g., oral retinoids, interferons, histone deacetylase [HDAC] inhibitors, extracorporeal photopheresis, methotrexate, systemic chemotherapeutic agents, Poteligeo). These patients are not required to step back and try a topical corticosteroid and topical imiquimod cream).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TASIGNA

Products Affected

- Tasigna oral capsule 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Stivarga). For ALL, Approve if the patient has tried one other tyrosine kinase inhibitor that is used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies or surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with a hematologist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Approve if the patient has tried one other therapy or the patient has undergone splenectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAZORAC

Products Affected

- tazarotene
- Tazorac

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic uses
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has a documented transthyretin (TTR) mutation verified by genetic testing AND the patient has symptomatic peripheral neuropathy (e.g., reduced motor strength/coordination, impaired sensation [e.g., pain, temperature, vibration, touch]).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if the patient has tried one other therapy (eg, ruxolitinib [Jakafi], danazol, epoetin alfa [Epogen/Procrit], prednisone, lenalidomide [Revlimid], hydroxyurea). Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). AIDS Related Kaposi's Sarcoma-approve if the patient has tried one regimen and has relapsed or refractory disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, Systemic Light Chain Amyloidosis, AIDS related Kaposi's Sarcoma, Castleman's Disease (relapsed/refractory or progressive).

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, IDH1 Status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPICAL AGENTS FOR ATOPIC DERMATITIS

Products Affected

- Elidel
- Eucrisa
- pimecrolimus
- Protopic
- tacrolimus topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL ALPHA-ADRENERGIC AGENTS FOR ROSACEA

Products Affected

- Mirvaso topical gel with pump
- Rhofade

PA Criteria	Criteria Details
Exclusion Criteria	Use in the treatment of erythema not caused by rosacea (ie, transient) [eg, during times of stress, sunburn, or skin irritation from cosmetic products].
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPICAL RETINOID PRODUCTS

Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene topical solution
- adapalene topical swab
- adapalene-benzoyl peroxide
- Altreno
- Atralin
- Avita topical cream
- Avita topical gel
- clindamycin-tretinoin
- Differin topical cream
- Differin topical gel 0.1 %
- Differin topical gel with pump
- Differin topical lotion
- Epiduo Forte
- Epiduo topical gel with pump
- Retin-A
- Retin-A Micro topical gel 0.04 %, 0.1 %
- Retin-A Micro topical gel with pump 0.06 %, 0.08 %
- tretinoin microspheres topical gel
- tretinoin topical
- Ziana

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL TESTOSTERONE PRODUCTS

Products Affected

- Androderm
- AndroGel transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)
- AndroGel transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- Fortesta
- Striant
- Testim
- testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)
- testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- testosterone transdermal solution in metered pump w/app
- Vogelxo transdermal gel in metered-dose pump
- Vogelxo transdermal gel in packet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. hypogonadism has

PA Criteria	Criteria Details
	been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPIRAMATE/ZONISAMIDE

Products Affected

- Qudexy XR
- Topamax
- topiramate oral capsule, sprinkle
- topiramate oral capsule,sprinkle,ER 24hr
- topiramate oral tablet
- Trokendi XR
- Zonegran oral capsule 100 mg, 25 mg
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRANSDERMAL FENTANYL

Products Affected

- Duragesic
- fentanyl

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRANSMUCOSAL FENTANYL DRUGS

Products Affected

- Abstral
- Actiq
- fentanyl citrate buccal lozenge on a handle
- fentanyl citrate buccal tablet, effervescent
- Fentora
- Lazanda nasal spray,non-aerosol 100 mcg/spray, 300 mcg/spray, 400 mcg/spray
- Subsys sublingual spray,non-aerosol 100 mcg/spray, 200 mcg/spray, 400 mcg/spray, 600 mcg/spray, 800 mcg/spray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRELEGY

Products Affected

- Trelegy Ellipta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	diagnosis, medication history
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Approve only if the patient has tried a single-entity LAMA AND fixed-dose combination LAMA/LABA in the past, unless the patient meets one of the following criteria: 1) Patient is currently receiving a fixed-dose LAMA/LABA combination product, OR 2) Patient currently receiving a LAMA + a LABA as two single-entity inhalers, OR 3) Patients currently receiving a fixed-dose ICS/LABA or an ICS + a LABA as two single-entity inhalers, patient must try a LAMA but does not need to try a fixed-dose LAMA/LABA combination product, OR 4) Patient current receiving an ICS, LAMA, and LABA (all three chemical classes in any combination of single-entity or combination products).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TREMFYA

Products Affected

- Tremfya

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Previous medication use
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	Initial therapy - 3 months, Continuation therapy - 3 years
Other Criteria	Initial Therapy - Approve if the patient has tried TWO of the following: Enbrel, Humira, Skyrizi, Stelara SC, Otezla, or Cosentyx. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tykerb is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	HER2-positive advanced or metastatic breast cancer, approve if Tykerb will be used in combination with Xeloda or Herceptin and the patient has received prior therapy with Herceptin. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man receiving a GnRH agonist, a premenopausal or perimenopausal woman receiving ovarian suppression/ablation with a GnRH agonist, surgical bilateral oophorectomy or ovarian radiation, or a postmenopausal woman and Tykerb will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or exemestane. In this criteria, man/woman is defined as an individual with the biological traits of a man/woman, regardless of the individual's gender identity or expression.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone cancer-chordoma

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, calcitonin nasal spray [Fortical], Forteo), except calcium and Vitamin D. Previous use of Tymlos and/or Forteo for a combined total no greater than 2 years duration during a patient's lifetime.
Required Medical Information	Previous medications tried, renal function
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 2 years of therapy over a patient's lifetime
Other Criteria	Treatment of PMO, approve if the patient meets ONE of the following criteria: patient has tried one oral bisphosphonate or cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or patient cannot remain in an upright position post oral bisphosphonate administration or patient has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR patient has severe renal impairment or CKD, OR patient has had an osteoporotic fracture or fragility fracture
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UDENYCA

Products Affected

- Udenyca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	Cancer pts receiving chemo-6 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if - the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmation of right heart catheterization, medication history.
Age Restrictions	N/A
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to Uptravi therapy must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL with or without 17p deletion - approve. SLL-approve. Mantle Cell Lymphoma-approve if the patient has tried one prior therapy. AML-approve if the patient is using Venclexta in combination with either azacitidine, decitabine, or cytarabine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Mantle Cell Lymphoma

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer in patients who have not had disease progression while on Kisqali, Ibrance or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Verzenio will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Verzenio will be used in combination with anastrozole, exemestane, or letrozole 3. Patient is postmenopausal and meets the following conditions: Verzenio will be used in combination with Faslodex. 4. patient is premenopausal or perimenopausal and meets the following conditions: The patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, or has had surgical bilateral oophorectomy or ovarian irradiation AND Verzenio will be used in combination with Faslodex 5. patient is postmenopausal, premenopausal/perimenopausal (patient is receiving ovarian suppression/ablation with GnRH agonist or has had surgical bilateral oophorectomy or ovarian irradiation) or a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) and

PA Criteria	Criteria Details
	meets the following conditions: Verzenio will be used as monotherapy AND patient's breast cancer has progressed on at least one prior endocrine therapy (e.g., anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol) AND patient has tried chemotherapy for metastatic breast cancer. 6. pt is a man who is receiving GnRH agonist AND Verzenio with be used in combination with anastrozole, exemestane or letrozole 7. Patient is a man and Verzenio will be used in combination with Faslodex
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Men with breast cancer

VIEKIRA

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Exclusion Criteria	Previous failure of Viekira/Viekira XR or Technivie in patients with minimal liver disease. Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	Genotype 1, Cirrhosis status and genotype 1 subtype
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. And, patients with genotype 1 must have a trial with Harvoni or Epclusa prior to approval of Viekira/Viekira XR, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

VITRAKVI

Products Affected

- Vitrakvi oral capsule 100 mg, 25 mg
- Vitrakvi oral solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, NTRK gene fusion status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, EGFR status, exon deletions or substitutions
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic-NSCLC-Epidermal Growth Factor Receptor (EGFR) mutation positive AND has epidermal growth factor receptor (EGFR) exon 19 deletion as detected by an approved test OR exon 21 (L858R) substitution mutations as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synvovial sarcoma, or solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has recurrent, advanced or metastatic disease. Advanced Renal Cell Carcinoma, Clear Cell or non-Clear Cell histology-approved if the patient has relapsed or stage IV disease. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary thyroid carcinoma.

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status, high level MET amplification status, MET Exon 14 skipping mutation, and ROS1 rearrangement required. For soft tissue sarcoma IMT, ALK translocation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC, patient new to therapy must be ALK-positive, have high level MET amplification, have MET Exon 14 skipping mutation, or have ROS1 rearrangement for approval. For IMT, patient new to therapy must have ALK translocation for approval.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, Plus peripheral T-Cell Lymphoma - Anaplastic Large Cell Lymphoma (ALCL), ALK PositivePlus NSCLC with high level MET amplification or MET Exon 14 skipping mutation.

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a Targeted Synthetic DMARD for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	PsA/RA-3 months initial, UC-16 weeks initial, All diagnoses-3 years cont.
Other Criteria	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). UC-Approve Xeljanz (not XR) if the patient has had a trial of one systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid) or was intolerant to one of these agents. Note-a previous trial of a biologic also counts as a trial of one systemic agent. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XENAZINE

Products Affected

- tetrabenazine oral tablet 12.5 mg, 25 mg
- Xenazine oral tablet 12.5 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	If the brand is requested the patient must have tried and cannot take generic tetrabenazine tablets as identified by the prescribing physician.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]) AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair subcutaneous recon soln
- Xolair subcutaneous syringe 150 mg/mL, 75 mg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
Required Medical Information	Moderate to severe persistent asthma and SAR/PAR, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). For SAR/PAR, patient has a baseline positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or baseline positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach). CIU - must have urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).
Age Restrictions	Moderate to severe persistent asthma-6 years and older. All other diagnoses-12 years and older
Prescriber Restrictions	Moderate to severe persistent asthma/SAR/PAR if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	Initial tx 4 months, continued tx 12 months
Other Criteria	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a)

PA Criteria	Criteria Details
	The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS for at least 3 consecutive months. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. SAR/PAR - approve if pt has tried concurrent therapy with at least one drug from two of the following classes: an oral non-sedating or low-sedating antihistamine, a nasal antihistamine, a nasal corticosteroid, or montelukast. For continued tx SAR/PAR - pt must have responded to therapy as determined by the prescribing physician. For CIU cont tx - must have responded to therapy as determined by the prescribing physician.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Seasonal or perennial allergic rhinitis (SAR or PAR).

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, FLT3-mutation status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XPOVIO

Products Affected

- Xpovio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Approve if the if the patient meets ALL of the following (A, B, and C): A) The patient has tried at least two proteasome inhibitors. Note: Examples include Velcade (bortezomib injection), Kyprolis (carfilzomib infusion), Ninlaro (ixazomib capsules) AND B) The patient has tried at least two immunomodulatory drugs. Note: Examples include Revlimid (lenalidomide capsules), Pomalyst (pomalidomide capsules), Thalomid (thalidomide capsules) AND C) The patient has tried an anti-CD38 monoclonal antibody.Note: For example, Darzalex (daratumumab infusion).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Xtandi is being used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a sleep specialist physician or a Neurologist
Coverage Duration	12 months.
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried two CNS stimulants (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy- approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-3 mo.All other=12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgramstim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia

PA Criteria	Criteria Details
	expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - approve if the patient has recurrent disease and is in complete or partial response after at least two lines of platinum-based chemotherapy regimen.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	BRAFV600 mutation status required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresctable, advanced or metastatic melanoma. HCL - must have relapsed or refractory disease AND tried at least two therapies for hairy cell leukemia. Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy. Erdheim-Chester disease, in patients with the BRAF V600 mutation-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin or Sovaldi.
Required Medical Information	Genotype, prior medication therapy, concurrent medications, NS5A polymorphism status, prescriber specialty
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or liver transplant MD.
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. And, patients with genotype 1 and genotype 4 must have a trial with Harvoni or Epclusa prior to approval of Zepatier, unless Harvoni and Epclusa are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Indications consistent with current AASLD/IDSA guidance

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CLL-approve if the patient has tried one prior therapy. Marginal Zone Lymphoma/Follicular B-Cell Non-Hodgkin Lymphoma/SLL - approve if the patient has tried two prior therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Marginal Zone Lymphoma

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Reaarangement. IMT - ALK Translocation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Patients with NSCLC with ROS1 Rearrangement-First-line therapy.

ZYTIGA

Products Affected

- abiraterone
- Zytiga oral tablet 250 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC) and Metastatic, Castration-Sensitive (mCSPC), high risk-Approve if abiraterone is being used in combination with prednisone. Prostate Cancer - Regional Risk Group or Locally Advanced. Approve if the patient meets all of the following criteria (A, B, and C): A)abiraterone is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i or ii): i.abiraterone with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide acetate for injection], Lupron Depot [leuprolide acetate for depot suspension], Trelstar [triptorelin pamoate for injectable suspension], Zoladex [goserelin acetate implant], Vantas [histrelin acetate subcutaneous implant]) OR ii. Patient has had an orchiectomy. Prostate Cancer - Metastatic (Castration-Resistant or Castration-Sensitive), Post-External Beam Radiation Therapy (EBRT)-Approve if the patient meets all of the following criteria (A, B, C, D, and E): A)abiraterone is used in combination with prednisone AND B) Patient meets one of the following criteria (i, ii, or iii): i.abiraterone with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide acetate for injection], Lupron Depot [leuprolide acetate for depot suspension], Trelstar [triptorelin pamoate for injectable suspension], Zoladex [goserelin acetate implant], Vantas [histrelin acetate subcutaneous implant]) OR ii.abiraterone with

PA Criteria	Criteria Details
	prednisone is used in combination with GnRH antagonist (e.g., Firmagon [degarelix for injection]) OR iii. Patient has had an orchiectomy. C) Patient meets one of the following criteria (i or ii): i. There is an increase in prostate specific antigen (PSA) after EBRT OR ii Patient has had a positive digital rectal exam (DRE) after EBRT AND D) Patient is not a candidate for local therapy AND E) Patient has had a positive bone scan.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Prostate Cancer-Regional Risk Group or Locally Advanced. Plus Prostate Cancer - Metastatic (Castration-Resistant or Castration-Sensitive), Post-External Beam Radiation Therapy (EBRT).

PART B VERSUS PART D

Products Affected

- Abelcet
- acetylcysteine
- Actimmune
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL
- AmBisome
- Aminosyn II 10 %
- Aminosyn II 15 %
- Aminosyn-PF 10 %
- Aminosyn-PF 7 % (sulfite-free)
- amphotericin B
- aprepitant
- Astagraf XL
- Azasan
- azathioprine
- Bethkis
- Brovana
- budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- Cancidas
- caspofungin
- CellCept
- Cesamet
- Clinimix 5%/D15W Sulfite Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 5%-D20W(sulfite-free)
- Clinimix E 2.75%/D5W Sulf Free
- Clinimix E 4.25%/D10W Sul Free
- Clinimix E 4.25%/D5W Sulf Free
- Clinimix E 5%/D15W Sulfit Free
- Clinimix E 5%/D20W Sulfit Free
- Clinisol SF 15 %
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine modified
- cyclosporine oral capsule
- dronabinol
- Duopa
- Emend
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular syringe
- Envarsus XR
- Firmagon kit w diluent syringe
- Freamine HBC 6.9 %
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution
- granisetron HCl oral
- Hepatamine 8%
- Imuran
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- Intron A injection
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl
- Marinol
- Medrol
- methotrexate sodium
- methotrexate sodium (PF) injection solution
- methylprednisolone oral tablet
- Millipred oral tablet
- mycophenolate mofetil
- mycophenolate sodium
- Myfortic
- Nebupent
- Neoral
- Nephramine 5.4 %
- Nutrilipid
- ondansetron
- ondansetron HCl oral
- Orapred ODT
- Perforomist
- Plenamine
- prednisolone sodium phosphate oral tablet,disintegrating
- Prednisone Intensol
- prednisone oral tablet
- Premasol 10 %
- Premasol 6 %

- Procalamine 3%
- Prograf oral
- Prosol 20 %
- Pulmicort inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- Pulmozyme
- Rapamune
- Rayos
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Sandimmune oral
- sirolimus
- Syndros
- Synribo
- tacrolimus oral
- Tobi
- tobramycin in 0.225 % NaCl
- Travasol 10 %
- Trelstar intramuscular suspension for reconstitution
- Trexall
- TrophAmine 10 %
- Trophamine 6%
- Varubi oral
- Ventavis
- Xatmep
- Xgeva
- Xopenex
- Xopenex Concentrate
- Yupelri
- Zofran oral tablet 8 mg
- Zortress
- Zuplenz

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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