# ABIRATERONE

## Products Affected

- Abiraterone Acetate
- Zytiga TABS 500MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Node-positive (N1), non-metastatic (M0) prostate cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ACITRETIN

## Products Affected

- Acitretin

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or contraindication to methotrexate or cyclosporine. |

# ACTIMMUNE

## Products Affected

- Actimmune

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Mycosis fungoides, Sezary syndrome. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ADEMPAS

## Products Affected

- Adempas

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# AIMOVIG

## Products Affected

- Aimovig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initial 3 Months, Reauthorization Plan Year |
| **Other Criteria** | N/A |

# ALDURAZYME

## Products Affected

- Aldurazyme

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For mucopolysaccharidosis I: Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ALECENSA

## Products Affected

- Alecensa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ALOSETRON

## Products Affected

- Alosetron Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ALPHA1-PROTEINASE INHIBITOR

## Products Affected

- Aralast Np INJ 1000MG, 500MG
- Prolastin-c
- Zemaira

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ALUNBRIG

## Products Affected

- Alunbrig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# AMBRISENTAN

## Products Affected

- Ambrisentan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ANADROL

## Products Affected

- Anadrol-50

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Cachexia associated with AIDS (HIV wasting) |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# APOKYN

## Products Affected

- Apokyn INJ 30MG/3ML

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

# ARCALYST

## Products Affected

- Arcalyst

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Prevention of gout flares in patients initiating or continuing urate-lowering therapy. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. |
| **Age Restrictions** | For Cryopyrin-Associated Periodic Syndromes (CAPS) and recurrent pericarditis: 12 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | For prevention of gout flares: 4 months. Other: Plan Year |
| **Other Criteria** | N/A |

# ARMODAFINIL

## Products Affected

- Armodafinil

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ASPARLAS

## Products Affected

- Asparlas

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 21 years of age or less |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ATYPICAL ANTIPSYCHOTICS

## Products Affected

- Caplyta
- Fanapt
- Fanapt Titration Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# AURYXIA

## Products Affected

- Auryxia

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The requested drug is not being prescribed for treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis |

# AUSTEDO

## Products Affected

- Austedo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Tourette's syndrome |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# AVASTIN

## Products Affected

- Avastin
- Zirabev

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, leptomeningeal metastases and metastatic spine tumors, malignant pleural mesothelioma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, AIDS-related Kaposi sarcoma, uterine cancer, endometrial cancer, vulvar cancer, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# AVONEX

## Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

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

# AYVAKIT

## Products Affected

- Ayvakit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For advanced systemic mastocytosis (AdvSM): 1) the patient has a diagnosis of advanced systemic mastocytosis including aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL) AND 2) the patient has a platelet count of greater than or equal to 50,000/mcL. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BALVERSA

## Products Affected

- Balversa

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

# BANZEL

## Products Affected

- Banzel
- Rufinamide

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 1 year of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BELEODAQ

## Products Affected

- Beleodaq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, extranodal NK/T-cell lymphoma (nasal type), hepatosplenic gamma-delta T-cell lymphoma, and primary cutaneous CD30+ T-cell lymphoproliferative disorders: cutaneous anaplastic large cell lymphoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BENLYSTA

## Products Affected

- Benlysta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | For patients new to therapy: severe active central nervous system lupus. |
| **Required Medical Information** | For systemic lupus erythematosus (SLE): 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid or antimalarial) for SLE OR 2) patient is not currently receiving stable standard therapy regimen for SLE because patient tried and had an inadequate response or intolerance to stable standard therapy regimen. For lupus nephritis: 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid) for lupus nephritis OR 2) patient is not currently receiving a stable standard therapy regimen for lupus nephritis because patient tried and had an inadequate response or intolerance to a stable standard therapy regimen. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BETASERON

## Products Affected

- Betaseron

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

# BEXAROTENE

## Products Affected

- Bexarotene
- Targretin GEL

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BLENREP

## Products Affected

- Blenrep

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

# BOSENTAN

## Products Affected

- Bosentan
- Tracleer TBSO

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Eisenmenger's syndrome |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. For Eisenmenger's syndrome: Patient is diagnosed with Eisenmenger's syndrome, WHO functional class III PAH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BOSULIF

## Products Affected

- Bosulif

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) patient has chronic phase CML (high, intermediate, or low risk for disease progression). If patient has low risk for disease progression (includes newly diagnosed), patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BRAFTOVI

## Products Affected

- Braftovi CAPS 75MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For colorectal cancer, patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600E mutation, 2) The disease is advanced or metastatic, and 3) The requested drug will be used as subsequent therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BRIVIACT

## Products Affected

- Briviact ORAL SOLN
- Briviact TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 1 month of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BRIVIACT INJ

## Products Affected

- Briviact INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 16 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# BRUKINSA

## Products Affected

- Brukinsa

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

# BUPRENORPHINE

## Products Affected

- Buprenorphine Hcl SUBL

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for the treatment of opioid use disorder AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 4) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 months |
| **Other Criteria** | N/A |

# BUPRENORPHINE PATCH

## Products Affected

- Buprenorphine PTWK

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CABOMETYX

## Products Affected

- Cabometyx

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-small cell lung cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive. For hepatocellular carcinoma: The patient has been previously treated with sorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CALCIPOTRIENE

## Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN
- Calcipotriene/betamethasone Dipropionate OINT
- Enstilar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CALQUENCE

## Products Affected

- Calquence

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

# CAPRELSA

## Products Affected

- Caprelsa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC: the requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CARBAGLU

## Products Affected

- Carbaglu

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CAYSTON

## Products Affected

- Cayston

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CERDELGA

## Products Affected

- Cerdelga

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CEREZYME

## Products Affected

- Cerezyme

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Type 3 Gaucher disease |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CHANTIX

## Products Affected

- Apo-varenicline
- Chantix TABS 0.5MG, 1MG
- Chantix Continuing Month Pak
- Chantix Starting Month Pak
- Varenicline Tartrate

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

# CLOBAZAM

## Products Affected

- Clobazam

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 2 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CLOMIPRAMINE

## Products Affected

- Clomipramine Hcl CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Depression, Panic Disorder |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CLORAZEPATE - 65

## Products Affected

- Clorazepate Dipotassium TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR The patient has experienced an inadequate treatment response, intolerance, or a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |

# CLOZAPINE ODT

## Products Affected

- Clozapine Odt

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

# COLY-MYCIN

## Products Affected

- Colistimethate Sodium INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Administration via nebulizer. |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Infectious disease specialist |
| **Coverage Duration** | Initial approval: 3 months, Renewal: Through end of plan contract year. |
| **Other Criteria** | Allow intravenous (IV) or intramuscularly (IM) use only. CMS endorsed compendia do not support inhalation/nebulization of colistimethate. |

# COMETRIQ

## Products Affected

- Cometriq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# COPIKTRA

## Products Affected

- Copiktra

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, splenic marginal zone lymphoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For follicular lymphoma: the requested drug will be used as second-line or subsequent therapy. For gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma: the requested drug will be used as subsequent therapy after at least 2 prior therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# COTELLIC

## Products Affected

- Cotellic

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

# CYSTAGON

## Products Affected

- Cystagon

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For nephropathic cystinosis: Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# CYSTARAN

## Products Affected

- Cystaran

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DALFAMPRIDINE

## Products Affected

- Dalfampridine Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient meets the following: patient demonstrates sustained walking impairment. For continuation of therapy, patient meets the following: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DAURISMO

## Products Affected

- Daurismo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Post remission therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory disease as a component of repeating the initial successful induction regimen for AML. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acute myeloid leukemia: 1) the requested medication must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, and 3) the requested medication will be used as treatment for induction therapy, post-remission therapy, or relapsed or refractory disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DEFERASIROX

## Products Affected

- Deferasirox

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DEMSER

## Products Affected

- Demser
- Metyrosine

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

# DESVENLAFAXINE

## Products Affected

- Desvenlafaxine Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DIACOMIT

## Products Affected

- Diacomit

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

# DIAZEPAM - 65

## Products Affected

- Diazepam CONC
- Diazepam INJ 5MG/ML
- Diazepam SOLN 5MG/5ML
- Diazepam TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR The patient has experienced an inadequate treatment response, intolerance, or a contraindication to AT LEAST TWO agents from the following classes: A) selective serotonin reuptake inhibitors (SSRIs), B) serotonin-norepinephrine reuptake inhibitors (SNRIs) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of spasticity caused by upper motor neuron disorders (e.g., cerebral palsy and paraplegia), athetosis, or stiff-man syndrome OR 4) For use as an adjunct for the relief of skeletal muscle spasms due to reflex spasm to local pathology (e.g., inflammation of the muscles or joints, or secondary to trauma) OR 5) For adjunctive therapy in the treatment of convulsive disorders OR 6) For the short-term relief of the symptoms of anxiety. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Short-term relief anx-1 mo, skeletal muscles spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |

# DICLOFENAC GEL 1%

## Products Affected

- Diclofenac Sodium GEL 1%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists, or elbows AND 2) Treatment with the requested drug is necessary due to concern of an intolerance or a contraindication to two oral nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DICLOFENAC SOLN

## Products Affected

- Pennsaid SOLN 2%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Treatment with the requested drug is necessary due to concern of an intolerance or a contraindication to two oral nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DOPTELET

## Products Affected

- Doptelet

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For thrombocytopenia associated with chronic liver disease: Baseline platelet (plt) count prior to a scheduled procedure is less than 50,000/mcL. For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused plt count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year |
| **Other Criteria** | N/A |

# DRIZALMA

## Products Affected

- Drizalma Sprinkle

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Cancer pain, chemotherapy-induced neuropathic pain |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration) |
| **Age Restrictions** | Generalized Anxiety Disorder - 7 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# DRONABINOL

## Products Affected

- Dronabinol

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chemotherapy-induced nausea and vomiting (CINV): The patient is receiving cancer chemotherapy AND has experienced an inadequate treatment response, intolerance, or contraindication to one oral 5HT-3 receptor antagonist. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# EMSAM

## Products Affected

- Emsam

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion OR 2) Patient is unable to swallow oral formulations. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ENBREL

## Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Severe, refractory hidradenitis suppurativa, graft versus host disease |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active rheumatoid arthritis (new starts only):1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ENDARI

## Products Affected

- Endari

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 5 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ENHERTU

## Products Affected

- Enhertu

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

# EPCLUSA

## Products Affected

- Epclusa TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| **Other Criteria** | N/A |

# EPIDIOLEX

## Products Affected

- Epidiolex

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

# EPO

## Products Affected

- Procrit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa). |
| **Exclusion Criteria** | Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. |
| **Required Medical Information** | For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 16 weeks |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin treatment in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, human immunodeficiency virus (HIV), hepatitis C treatment, anemia due to myelosuppressive cancer chemotherapy, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than 12 g/dL. |

# ERIVEDGE

## Products Affected

- Erivedge

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Adult medulloblastoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Adult medulloblastoma: patient has received chemotherapy previously AND has tumor(s) with mutations in the sonic hedgehog pathway |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ERLEADA

## Products Affected

- Erleada

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For all indications: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ERLOTINIB

## Products Affected

- Erlotinib Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced non-small cell lung cancer (NSCLC), recurrent chordoma, renal cell carcinoma (RCC), brain metastases from NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the member has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, or metastatic. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ESBRIET

## Products Affected

- Esbriet

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# EVEROLIMUS

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Classic Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: The disease is relapsed or metastatic. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# EXKIVITY

## Products Affected

- Exkivity

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

# FABRAZYME

## Products Affected

- Fabrazyme

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Fabry disease: diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# FARYDAK

## Products Affected

- Farydak

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

# FASENRA

## Products Affected

- Fasenra
- Fasenra Pen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For severe asthma: For initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). For continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. |
| **Age Restrictions** | 12 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# FENTANYL PATCH

## Products Affected

- Fentanyl PT72

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# FETZIMA

## Products Affected

- Fetzima
- Fetzima Titration Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# FILGRASTIM

## Products Affected

- Zarxio

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation-related indications, neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation. |
| **Exclusion Criteria** | Use of the requested product within 24 hours prior to or following chemotherapy. |
| **Required Medical Information** | For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patients must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# FINTEPLA

## Products Affected

- Fintepla

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

# FLUOROURACIL

## Products Affected

- Fluoroplex CREA
- Fluorouracil CREA

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Members who are pregnant or may become pregnant. Fluorouracil cream 5% only: Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Applies to new starts only. If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. |

# FORTAMET/GLUMETZA

## Products Affected

- Metformin Hydrochloride Er TB24
  500MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The patient experienced an intolerance to generic Glucophage XR. |

# FORTEO

## Products Affected

- Forteo INJ 620MCG/2.48ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND 2) patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) |
| **Other Criteria** | Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. |

# FOTIVDA

## Products Affected

- Fotivda

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

# FYCOMPA

## Products Affected

- Fycompa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | Partial-onset seizures: 4 years of age or older, Primary generalized tonic-clonic seizures: 12 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# GATTEX

## Products Affected

- Gattex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For short bowel syndrome (SBS) initial therapy: Adult patients were dependent on parenteral support for at least 12 months. Pediatric patients were dependent on nutrition/IV fluids to account for at least 30 percent of caloric and/or fluid/electrolyte needs. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# GAVRETO

## Products Affected

- Gavreto

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# GILENYA

## Products Affected

- Gilenya CAPS 0.5MG

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

# GILOTRIF

## Products Affected

- Gilotrif

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Brain metastases from non-small cell lung cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or 2) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC: Patient has a known sensitizing EGFR mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# GLATIRAMER

## Products Affected

- Copaxone INJ 20MG/ML, 40MG/ML

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

# GROWTH HORMONE

## Products Affected

- Genotropin
- Genotropin Miniquick

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Pediatric patients with closed epiphyses (except in patients with PWS). |
| **Required Medical Information** | Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx. |
| **Age Restrictions** | SGA: 2 years of age or older |
| **Prescriber Restrictions** | Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist. |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement. |

# HAEGARDA

## Products Affected

- Haegarda

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hereditary angioedema (HAE): The requested drug is being used for the prevention of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation, OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# HARVONI

## Products Affected

- Harvoni

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate. |
| **Other Criteria** | N/A |

# HERCEPTIN

## Products Affected

- Herceptin INJ 150MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year. |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# HERCEPTIN HYLECTA

## Products Affected

- Herceptin Hylecta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Neoadjuvant therapy for breast cancer: 6 months, Other: Plan Year. |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# HETLIOZ

## Products Affected

- Hetlioz

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in both eyes, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) for initial therapy and continuation of therapy, the patient has a confirmed diagnosis of SMS AND 2) if currently on therapy with the requested drug, the patient experiences improvement in the quality of sleep since starting therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initiation: 6 Months, Renewal: Plan Year |
| **Other Criteria** | N/A |

# HETLIOZ LQ

## Products Affected

- Hetlioz Lq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For nighttime sleep disturbances in Smith-Magenis Syndrome: 1) for initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) if currently on therapy with the requested drug, the patient experiences improvement in the quality of sleep since starting therapy. |
| **Age Restrictions** | 3 to 15 years of age |
| **Prescriber Restrictions** | Sleep disorder specialist or neurologist |
| **Coverage Duration** | Initiation: 6 Months, Renewal: Plan Year. |
| **Other Criteria** | N/A |

# HIGH RISK MEDICATION - 65

## Products Affected

- Chlordiazepoxide/amitriptyline
- Chlorzoxazone TABS 250MG, 500MG
- Dihydroergotamine Mesylate INJ
- Dihydroergotamine Mesylate SOLN
- Diphenhydramine Hcl INJ 50MG/ML
- Dipyridamole TABS
- Disopyramide Phosphate CAPS
- Guanfacine Er
- Guanfacine Hcl
- Ketorolac Tromethamine INJ 15MG/ML, 30MG/ML
- Ketorolac Tromethamine TABS
- Meprobamate
- Methscopolamine Bromide TABS
- Methyldopa TABS 250MG, 500MG
- Perphenazine/amitriptyline
- Thioridazine Hcl TABS 100MG, 10MG, 25MG, 50MG
- Trimethobenzamide Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HIGH RISK MEDICATIONS - CYPROHEPTADINE - 65

## Products Affected

- Cyproheptadine Hcl SYRP
- Cyproheptadine Hydrochloride TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Pruritus, spasticity due to spinal cord injury |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM - ANTICONVULSANTS - 65

## Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG
- Phenobarbital Sodium INJ 130MG/ML, 65MG/ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Epilepsy |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM - ANTIHISTAMINES (EXCLUDING HYDROXYZINE, PROMETHAZINE) - 65

## Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Clemastine Fumarate TABS 2.68MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>1) If the requested drug is being prescribed for rhinitis, the patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient has experienced an inadequate treatment response or intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) If the requested drug is being prescribed for the symptomatic treatment of mild, uncomplicated allergic skin manifestations of urticaria or angioedema, the prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 5) Carbinoxamine is being prescribed for one of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 6) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient . |

# HRM - HYPNOTICS - 65

## Products Affected

- Eszopiclone
- Zaleplon
- Zolpidem Tartrate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>1) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 3) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient |

# HRM - SCOPOLAMINE - 65

## Products Affected

- Scopolamine PT72 1MG/3DAYS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Excessive Salivation |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM-ANTIDEPRESSANTS TCA - 65

## Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 10MG, 50MG
- Doxepin Hcl CAPS 100MG, 10MG, 150MG, 50MG, 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 25MG
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Trimipramine Maleate CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Neuropathic pain for amitriptyline or imipramine |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | If the requested drug is being prescribed for the treatment of depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone<br>If doxepin is being prescribed for the treatment of anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient |

# HRM-ANTIPARKINSON - 65

## Products Affected

- Benztropine Mesylate TABS
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has tried the non-HRM alternative drug amantadine AND 5) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM-HYDROXYZINE - 65

## Products Affected

- Hydroxyzine Hcl SYRP
- Hydroxyzine Hcl TABS 50MG
- Hydroxyzine Hydrochloride TABS 10MG, 25MG
- Hydroxyzine Pamoate CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 5) The patient has acute anxiety AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 7) If being requested for pruritus, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM-HYDROXYZINE INJ - 65

## Products Affected

- Hydroxyzine Hcl INJ 25MG/ML
- Hydroxyzine Hydrochloride INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)<br><br>Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. Anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has not tried two of the following alternative drugs: |

| | |
|---|---|
| | buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 5) The patient has acute anxiety AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM-PROMETHAZINE - 65

## Products Affected

- Phenadoz
- Promethazine Hcl INJ
- Promethazine Hcl SUPP 12.5MG, 25MG
- Promethazine Hcl TABS 12.5MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 25MG, 50MG
- Promethegan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. |

# HRM-SKELETAL MUSCLE RELAXANTS - 65

## Products Affected

- Cyclobenzaprine Hydrochloride
  TABS 10MG, 5MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 3 months |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. |

# HUMIRA

## Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Axial spondyloarthritis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# HYPNOTIC-BENZODIAZEPINES - 65

## Products Affected

- Temazepam CAPS 15MG, 22.5MG, 7.5MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 3) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older OR 4) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR. |

# IBRANCE

## Products Affected

- Ibrance

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Unresectable well-differentiated/dedifferentiated liposarcoma, recurrent hormone receptor (HR)-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with an aromatase inhibitor or fulvestrant. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ICATIBANT

## Products Affected

- Icatibant Acetate
- Sajazir

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ICLUSIG

## Products Affected

- Iclusig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Follow-up therapy after hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML) and ALL patients. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# IDHIFA

## Products Affected

- Idhifa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Newly-diagnosed acute myeloid leukemia |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient is 60 years of age or older with newly-diagnosed AML and meets one of the following: a) patient has comorbidities that preclude use of intensive induction chemotherapy, or b) patient declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-remission therapy following response to previous lower intensity therapy with the same regimen, OR 3) patient has relapsed or refractory AML. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# IMATINIB

## Products Affected

- Imatinib Mesylate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, melanoma, AIDS-related Kaposi sarcoma, and chronic myelomonocytic leukemia. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma: c-Kit mutation is positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# IMBRUVICA

## Products Affected

- Imbruvica

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: 1) the disease is relapsed or refractory and 2) the requested drug is used as a single agent. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. For high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For follicular lymphoma: the requested drug will be used as a single agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |

| | |
|---|---|
| **Other Criteria** | N/A |

# IMLYGIC

## Products Affected

- Imlygic

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

# INCRELEX

## Products Affected

- Increlex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For renewal, patient is experiencing improvement. |

# INLYTA

## Products Affected

- Inlyta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Papillary, Hurthle cell, or follicular thyroid carcinoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# INQOVI

## Products Affected

- Inqovi

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

# INREBIC

## Products Affected

- Inrebic

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

# IR BEFORE ER

## Products Affected

- Hydrocodone Bitartrate Er T24A
- Hysingla Er
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadone Hydrochloride CONC
- Morphine Sulfate Er CP24
- Morphine Sulfate Er TBCR
- Tramadol Hcl Er CP24 100MG, 200MG, 300MG
- Tramadol Hcl Er TB24

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# IRESSA

## Products Affected

- Iressa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from epidermal growth factor receptor (EGFR) mutation-positive NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC (including brain metastases from NSCLC), patient has a sensitizing EGFR mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ISOTRETINOIN

## Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Myorisan
- Zenatane

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Refractory acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ITRACONAZOLE

## Products Affected

- Itraconazole CAPS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea capitis, Tinea manuum/Tinea pedis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# IVERMECTIN TAB

## Products Affected

- Ivermectin TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 1 month |
| **Other Criteria** | N/A |

# IVIG

## Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam
- Panzyga
- Privigen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# JAKAFI

## Products Affected

- Jakafi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Low-risk myelofibrosis, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, or pediatric acute lymphoblastic leukemia (ALL). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea. For pediatric acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# JUXTAPID

## Products Affected

- Juxtapid

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For initiation of therapy to treat homozygous familial hypercholesterolemia: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin or experienced statin-intolerance, fibrate, bile acid sequestrant, ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the Food and Drug Administration (FDA), AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated low-density lipoprotein cholesterol (LDL-C) greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy to treat HoFH: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or LDL receptor adaptor protein/ARH gene locus, OR 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of familial hypercholesterolemia (FH) by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature atherosclerotic cardiovascular disease |

| | |
|---|---|
| | (ASCVD) [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative 60 years of age or younger or in a second degree relative 50 years of age or younger, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points. |

# KALYDECO

## Products Affected

- Kalydeco

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystic fibrosis (CF): The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. |
| **Age Restrictions** | 4 months of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The requested medication will not be used in combination with other medications containing ivacaftor. |

# KETOCONAZOLE

## Products Affected

- Ketoconazole TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Cushing's syndrome. |
| **Exclusion Criteria** | Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin. |
| **Required Medical Information** | 1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# KEYTRUDA

## Products Affected

- Keytruda INJ 100MG/4ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, uveal melanoma, Ewing sarcoma, osteosarcoma, testicular cancer, anal carcinoma, adrenal gland tumors, penile cancer, central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer (NSCLC), pancreatic adenocarcinoma, hepatobiliary cancers (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer), malignant pleural mesothelioma, vulvar cancer, thymic carcinoma, Mycosis Fungoides/Sezary syndrome, T-cell lymphomas (extranodal natural killer [NK]/T-cell lymphoma, nasal type), gestational trophoblastic neoplasia, poorly differentiated neuroendocrine carcinoma/large or small cell carcinoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cutaneous melanoma: Disease is unresectable or metastatic. For adjuvant treatment of melanoma: 1) The disease has spread to lymph nodes and 2) The requested drug will be used following complete lymph node resection or complete resection of metastatic disease. For NSCLC: Patient must meet any of the following conditions: 1) Will be used in combination with pemetrexed and carboplatin or cisplatin following epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) therapy (if EGFR or ALK positive) for recurrent, advanced, or metastatic nonsquamous NSCLC, OR 2) Will be used with carboplatin or cisplatin and paclitaxel or paclitaxel protein-bound for recurrent, advanced, or metastatic squamous NSCLC, OR 3) Will be used as a single agent for recurrent, advanced, or metastatic NSCLC expressing programmed death ligand 1 (PD-L1) (Tumor Proportion Score [TPS] greater than or equal to 1%) following EGFR or ALK therapy (if EGFR or ALK positive), OR 4) Will be used for continuation maintenance therapy for recurrent, advanced or metastatic disease. For head and neck squamous cell carcinoma: Disease is unresectable, metastatic, or second primary. For classical Hodgkin lymphoma: The disease is relapsed or refractory. For urothelial carcinoma (other than non-muscle invasive bladder cancer [NMIBC] with carcinoma in situ [CIS]): 1) Patient is not eligible for cisplatin and tumor expresses PD-L1 (Combined Positive Score [CPS] greater than or equal to 10), OR 2) Patient is not eligible for any platinum-containing chemotherapy, OR 3) Disease has progressed during, following, or within 12 months of neoadjuvant or adjuvant platinum therapy. For NMIBC with CIS: Disease is high-risk and Bacillus Calmette-Guerin (BCG)-unresponsive AND patient is ineligible for or has |

| | |
|---|---|
| | elected not to undergo cystectomy. For colorectal cancer: 1) Disease is unresectable or metastatic, AND 2) Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For solid tumors (including Ewing sarcoma, osteosarcoma, adrenal gland tumors, penile cancer): 1) Disease is unresectable or metastatic, AND 2) Tumor is MSI-H or dMMR or tumor mutational burden-high (greater than or equal to 10 mutations per megabase), AND 3) Disease has progressed following prior treatment and patient has no satisfactory alternative treatment options. For gastric, esophagogastric junction, and esophageal cancer: 1) Member is not a surgical candidate or disease is recurrent, locally advanced, or metastatic, AND 2) Tumor is MSI-H or dMMR OR tumor expresses PD-L1 (CPS greater than or equal to 1). For cervical cancer: Disease is recurrent or metastatic AND one of the following: 1) Tumor is MSI-H or dMMR, OR 2) Tumor expresses PD-L1 (CPS greater than or equal to 1) and disease has progressed on or after chemotherapy. For primary mediastinal large B-cell lymphoma: Disease is relapsed or refractory. For hepatocellular carcinoma: Patient was previously treated with sorafenib. For kidney cancer: The requested drug will be used in combination with axitinib. For small cell lung cancer: Disease is relapsed, primary progressive, or metastatic. For CNS brain metastases: The requested drug will be used for treatment of brain metastases in patients with melanoma or NSCLC. |

# KISQALI

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For treatment of breast cancer using Kisqali (ribociclib) in combination with an aromatase inhibitor or Kisqali Femara Co-Pack (ribociclib and letrozole) as initial endocrine-based therapy, one the following criteria must be met: 1) the patient is pre- or peri-menopausal, OR 2) the patient is postmenopausal and the patient has experienced disease progression on Ibrance (palbociclib) or Verzenio (abemaciclib) or an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib). For treatment of breast cancer with Kisqali (ribociclib) in combination with fulvestrant, one of the following criteria must met: 1) the requested drug is being used with fulvestrant as initial endocrine-based therapy in a postmenopausal patient, OR 2) the requested drug is being used following disease progression on endocrine therapy in a postmenopausal patient and the patient has experienced disease progression on Ibrance (palbociclib) OR Verzenio (abemaciclib) OR an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib). |

# KORLYM

## Products Affected

- Korlym

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

# KUVAN

## Products Affected

- Kuvan
- Sapropterin Dihydrochloride

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For phenylketonuria: For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initial: 2 months. All others: Plan Year. |
| **Other Criteria** | N/A |

# KYNMOBI

## Products Affected

- Kynmobi

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

# LENVIMA

## Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Medullary thyroid carcinoma, anaplastic thyroid carcinoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is radioactive iodine-refractory and unresectable, locally recurrent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma: disease is advanced or relapsed. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LIBTAYO

## Products Affected

- Libtayo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cutaneous squamous cell carcinoma: patient meets both of the following: 1) disease is one of the following: a) metastatic, b) locally advanced, or c) regional and inoperable or incompletely resected, and 2) patient is not a candidate for curative surgery or curative radiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LIDOCAINE PATCHES

## Products Affected

- Lidocaine PTCH 5%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LINEZOLID

## Products Affected

- Linezolid

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The infection is proven or strongly suspected to be caused by susceptible bacteria. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed or directed by an Infectious Disease specialist when being converted from intravenous (IV) linezolid (Zyvox). |
| **Coverage Duration** | 28 days |
| **Other Criteria** | N/A |

# LONSURF

## Products Affected

- Lonsurf

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For colorectal cancer: The disease is unresectable advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LORBRENA

## Products Affected

- Lorbrena

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Repressor of silencing (ROS)-1 rearrangement-positive metastatic NSCLC following progression on crizotinib, entrectinib, or ceritinib. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LUMAKRAS

## Products Affected

- Lumakras

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

# LUMIZYME

## Products Affected

- Lumizyme

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Pompe disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LUMOXITI

## Products Affected

- Lumoxiti

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hairy cell leukemia, the patient has not previously received 6 or more cycles of treatment with the requested drug. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# LUPRON

## Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML
- Lupron Depot (1-month) INJ 3.75MG
- Lupron Depot (3-month) INJ 11.25MG
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. |
| **Age Restrictions** | CPP: Patient must be less than 12 years old if female and less than 13 years old if male. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year |
| **Other Criteria** | N/A |

# LYNPARZA

## Products Affected

- Lynparza TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For breast cancer the disease must be: 1) BRCA 1/2-germline mutated, and 2) recurrent or metastatic |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# LYRICA CR

## Products Affected

- Lyrica Cr
- Pregabalin Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# MAVYRET

## Products Affected

- Mavyret TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). |
| **Required Medical Information** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| **Other Criteria** | N/A |

# MEKINIST

## Products Affected

- Mekinist

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Brain metastases from melanoma, uveal melanoma, colorectal cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For brain metastasis from melanoma or for adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer or for anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent. For unresectable advanced or metastatic colorectal cancer, the tumor is positive for a BRAF V600E activating mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# MEKTOVI

## Products Affected

- Mektovi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Colorectal cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For colorectal cancer, patient must meet all of the following criteria: 1) The requested drug is used in combination with encorafenib, 2) Tumor is positive for BRAF V600E mutation, and 3) The requested drug will be used as subsequent therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# MEMANTINE

## Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN 2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This edit only applies to patients less than 30 years of age. |

# MEPRON

## Products Affected

- Atovaquone SUSP

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All Medically-accepted Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year. |
| **Other Criteria** | Mild-to-moderate Pneumocystis jiroveci pneumonia/Prevention of Pneumocystis jiroveci pneumonia: Member must have tried and failed, or has a contraindication or intolerance to sulfamethoxazole/trimethoprim (SMZ/TMP). |

# MIGLUSTAT

## Products Affected

- Miglustat

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# MODAFINIL

## Products Affected

- Modafinil

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is shift work disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# MONJUVI

## Products Affected

- Monjuvi

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

# MYLOTARG

## Products Affected

- Mylotarg

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Acute promyelocytic leukemia (APL). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NAGLAZYME

## Products Affected

- Naglazyme

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For mucopolysaccharidosis VI disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NATPARA

## Products Affected

- Natpara

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism. |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NAYZILAM

## Products Affected

- Nayzilam

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 12 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year. |
| **Other Criteria** | N/A |

# NERLYNX

## Products Affected

- Nerlynx

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

# NEXAVAR

## Products Affected

- Nexavar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, solitary fibrous tumor, and hemangiopericytoma subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For thyroid carcinoma: Histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia, any of the following criteria must be met: 1) The requested drug is used in combination with azactidine or decitabine for low-intensity treatment induction or post-remission therapy AND the patient is 60 years of age or older with FLT3-ITD mutation, OR 2) The disease is relapsed/refractory AND the requested drug is a component of repeating the initial successful induction if late relapse (greater than or equal to 12 months), OR 3) The disease is relapsed/refractory AND the requested drug is used in combination with azactidine or decitabine if the patient is FLT3-ITD mutation positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NINLARO

## Products Affected

- Ninlaro

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Systemic light chain amyloidosis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone OR cyclophosphamide and dexamethasone OR as a single agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NITISINONE

## Products Affected

- Nitisinone
- Orfadin CAPS 20MG
- Orfadin SUSP

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NITYR

## Products Affected

- Nityr

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# NORTHERA

## Products Affected

- Droxidopa
- Northera

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For neurogenic orthostatic hypotension (NOH): Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. For both initial and continuation of therapy for NOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 3 months |
| **Other Criteria** | N/A |

# NP MULTIPLE SCLEROSIS

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | MS: Neurologist |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease as specified in the Prescribing Information for the requested drug]: Member must have tried and failed or has a contraindication or intolerance to two of the following: Betaseron (interferon beta-1b), Gilenya (fingolimod), Copaxone, brand Tecfidera. |

# NUBEQA

## Products Affected

- Nubeqa

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

# NUEDEXTA

## Products Affected

- Nuedexta

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

# NUPLAZID

## Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# OCTREOTIDE

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Meningiomas, thymomas and thymic carcinomas, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, lung, thymus (carcinoid tumors) or unresected primary gastrinoma, NETs of the pancreas, and pheochromocytoma/paraganglioma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy. |

# ODOMZO

## Products Affected

- Odomzo

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

# OFEV

## Products Affected

- Ofev

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

# ONCASPAR

## Products Affected

- Oncaspar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Extranodal natural killer/T-cell lymphoma (nasal type). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For extranodal natural killer/T-cell lymphoma (nasal type) and acute lymphoblastic leukemia: the requested drug must be used in conjunction with multi-agent chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ONUREG

## Products Affected

- Onureg

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

# OPSUMIT

## Products Affected

- Opsumit

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ORACEA

## Products Affected

- Doxycycline CPDR
- Oracea

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Member must have tried and failed, or has a contraindication or intolerance to formulary generic topical metronidazole. |

# ORAL-INTRANASAL FENTANYL

## Products Affected

- Fentanyl Citrate Oral Transmucosal

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.] AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.] |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ORGOVYX

## Products Affected

- Orgovyx

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

# ORKAMBI

## Products Affected

- Orkambi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene. |
| **Age Restrictions** | 2 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor. |

# OXANDROLONE

## Products Affected

- Oxandrolone TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Cachexia associated with AIDS (HIV wasting) or to enhance growth in patients with Turner's Syndrome. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Coverage will be denied if request is for an indication excluded from Part D. |

# PADCEV

## Products Affected

- Padcev

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

# PEGASYS

## Products Affected

- Pegasys

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis), systemic mastocytosis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr |
| **Other Criteria** | N/A |

# PEMAZYRE

## Products Affected

- Pemazyre

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

# PEPAXTO

## Products Affected

- Pepaxto

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

# PHENYLBUTYRATE

## Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# PHESGO

## Products Affected

- Phesgo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year |
| **Other Criteria** | N/A |

# PIQRAY

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# POLIVY

## Products Affected

- Polivy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | High-grade B-cell lymphomas |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For diffuse large B-cell lymphomas and high-grade B-cell lymphomas: 1) The requested drug is used in combination with bendamustine and a rituximab product, AND 2) Patient has received at least two prior therapies, AND 3) Disease is partially responsive, not responsive, relapsed, refractory, or progressive after prior therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# POMALYST

## Products Affected

- Pomalyst

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi sarcoma, patient meets one of the following: 1) patient has acquired immunodeficiency syndrome (AIDS), or 2) patient is negative for human immunodeficiency virus (HIV). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# POTELIGEO

## Products Affected

- Poteligeo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Adult T-cell leukemia/lymphoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# PRALUENT

## Products Affected

- Praluent

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

# PREGABALIN

## Products Affected

- Pregabalin CAPS
- Pregabalin SOLN

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Cancer-related neuropathic pain, cancer treatment related neuropathic pain. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for the management of postherpetic neuralgia, neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain or cancer treatment related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or management of neuropathic pain associated with spinal cord injury. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# PRETOMANID

## Products Affected

- Pretomanid

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

# PROMACTA

## Products Affected

- Promacta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks |
| **Other Criteria** | APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL) |

# PULMOZYME

## Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# QINLOCK

## Products Affected

- Qinlock

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

# QUETIAPINE XR

## Products Affected

- Quetiapine Fumarate Er

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# QUININE SULFATE

## Products Affected

- Quinine Sulfate CAPS 324MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Babesiosis, uncomplicated Plasmodium vivax malaria. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 1 month |
| **Other Criteria** | N/A |

# REGRANEX

## Products Affected

- Regranex

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 20 weeks |
| **Other Criteria** | N/A |

# RELISTOR INJ

## Products Affected

- Relistor INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik) OR 6) The patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: An example of an oral drug indicated for opioid-induced constipation includes Movantik). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 4 months |
| **Other Criteria** | N/A |

# RENFLEXIS

## Products Affected

- Renflexis

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# RETEVMO

## Products Affected

- Retevmo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive. |
| **Age Restrictions** | Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# REVLIMID

## Products Affected

- Revlimid

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, myeloproliferative neoplasms, non-Hodgkin's lymphoma with the following subtypes: acquired immunodeficiency syndrome (AIDS)-related diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL), hepatosplenic gamma-delta T-cell lymphoma, high-grade B-cell lymphomas. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia per the International Prognostic Scoring System (IPSS) scale |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# REZUROCK

## Products Affected

- Rezurock

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 12 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# RINVOQ

## Products Affected

- Rinvoq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active rheumatoid arthritis (new starts only): 1) inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# RITUXAN

## Products Affected

- Rituxan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, and immune checkpoint inhibitor-related toxicities |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year |

| | |
|---|---|
| **Other Criteria** | N/A |

# RITUXAN HYCELA

## Products Affected

- Rituxan Hycela

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma, Burkitt lymphoma, Castleman's disease (CD), high-grade B-cell lymphoma, small lymphocytic lymphoma (SLL), gastric mucosa-associated lymphoid tissue (MALT) lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), post-transplant lymphoproliferative disorder (PTLD), splenic marginal zone lymphoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ROZLYTREK

## Products Affected

- Rozlytrek

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

# RUBRACA

## Products Affected

- Rubraca

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

# RYDAPT

## Products Affected

- Rydapt

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Relapsed or refractory acute myeloid leukemia |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SARCLISA

## Products Affected

- Sarclisa

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

# SIGNIFOR

## Products Affected

- Signifor

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

# SILDENAFIL

## Products Affected

- Sildenafil INJ
- Sildenafil Citrate TABS 20MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SIRTURO

## Products Affected

- Sirturo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | N/A |

# SKYRIZI

## Products Affected

- Skyrizi
- Skyrizi Pen

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SOMATULINE DEPOT

## Products Affected

- Somatuline Depot

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, lung, thymus (carcinoid tumors) or unresected primary gastrinoma, NETs of the pancreas, and pheochromocytoma/paraganglioma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. |

# SOMAVERT

## Products Affected

- Somavert

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acromegaly (initial): 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. |

# SPRITAM

## Products Affected

- Spritam

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | Partial Onset Seizures: 4 years of age or older. Myoclonic Seizures: 12 years of age or older. Primary Generalized Tonic-Clonic Seizures: 6 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SPRYCEL

## Products Affected

- Sprycel

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) for chronic phase CML (includes newly diagnosed), the patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For gastrointestinal stromal tumor (GIST), patient must have progressed on imatinib, sunitinib, or regorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# STELARA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For moderate to severe plaque psoriasis (new starts): the patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active psoriatic arthritis (PsA) (new starts): the patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Xeljanz (tolfacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active Crohn's disease (new starts): patient had an inadequate response, intolerance, or contraindication to Humira (adalimumab). For moderately to severely active ulcerative colitis (new starts): patient had an inadequate response, intolerance, or contraindication to both Humira (adalimumab) and Xeljanz (tolfacitinib)/Xeljanz XR (tofacitinib extended-release). |

# STIVARGA

## Products Affected

- Stivarga

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Progressive gastrointestinal stromal tumors (GIST), retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, and soft tissue sarcomas of the extremities, superficial trunk, head and neck, unresectable or advanced colorectal cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SUTENT

## Products Affected

- Sunitinib Malate
- Sutent

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and hemangiopericytoma subtypes), gastrointestinal stromal tumor, recurrent chordoma, thymic carcinoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For renal cell carcinoma, any of the following criteria must be met: 1) The disease is relapsed or metastatic, OR 2) The patient is at high risk of disease recurrence following nephrectomy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SYLATRON

## Products Affected

- Sylatron INJ 200MCG, 300MCG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SYMDEKO

## Products Affected

- Symdeko

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. |
| **Age Restrictions** | 6 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | The requested medication will not be used in combination with other medications containing ivacaftor. |

# SYMLIN

## Products Affected

- Symlinpen 120
- Symlinpen 60

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

# SYMPAZAN

## Products Affected

- Sympazan

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 2 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SYNRIBO

## Products Affected

- Synribo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# SYPRINE

## Products Affected

- Clovique
- Trientine Hydrochloride

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

# TABRECTA

## Products Affected

- Tabrecta

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Treatment of recurrent or advanced non-small cell lung cancer (NSCLC). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TADALAFIL (PAH)

## Products Affected

- Alyq
- Tadalafil TABS 20MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TAFINLAR

## Products Affected

- Tafinlar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), colorectal cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For brain metastases from melanoma or for adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology. For unresectable advanced or metastatic colorectal cancer, the tumor is positive for a BRAF V600E activating mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TAGRISSO

## Products Affected

- Tagrisso

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, brain metastases from EGFR T790M mutation-positive NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For recurrent, advanced or metastatic NSCLC (including brain metastases from NSCLC), patient must have a sensitizing EGFR mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TALTZ

## Products Affected

- Taltz

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderate to severe plaque psoriasis (new starts only): At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis. |
| **Age Restrictions** | For plaque psoriasis: 6 years of age or older. Other: 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | For moderate to severe plaque psoriasis (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Skyrizi (risankizumab-rzaa). For active ankylosing spondylitis (new starts only): the patient had an inadequate response, intolerance, or contraindication to either Enbrel (etanercept) or Humira (adalimumab). For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active axial spondyloarthritis (new starts only): Patient meets any of the following: 1) has an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial or 2) has an intolerance or contraindication to NSAIDs. |

# TALZENNA

## Products Affected

- Talzenna

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent, BRCA 1/2-germline mutated breast cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TASIGNA

## Products Affected

- Tasigna

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) patient received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) for chronic phase CML (includes newly diagnosed), the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TAZAROTENE

## Products Affected

- Tazarotene CREA
- Tazorac CREA 0.05%

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TAZVERIK

## Products Affected

- Tazverik

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TECENTRIQ

## Products Affected

- Tecentriq

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For urothelial carcinoma, patient meets one of the following criteria: 1) Patient is ineligible for cisplatin therapy and tumors express PD-L1, OR 2) Patient is ineligible for any platinum containing chemotherapy, OR 3) The requested medication will be used as subsequent therapy following platinum-containing chemotherapy. For non-small cell lung cancer (NSCLC), patient meets one of the following criteria: 1) The requested medication will be used as treatment for NSCLC AND patients with EGFR or ALK positive disease must have received previous EGFR or ALK therapy, OR 2) The requested medication will be used as continuation maintenance therapy when tumor response or stable disease is achieved following initial systemic therapy, OR 3) The requested medication will be used as subsequent therapy for recurrent, advanced, or metastatic NSCLC. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TECFIDERA

## Products Affected

- Tecfidera
- Tecfidera Starter Pack

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

# TEMAZEPAM 30MG - 65

## Products Affected

- Temazepam CAPS 30MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 3) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older. OR 4) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 5) The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |

# TEPMETKO

## Products Affected

- Tepmetko

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

# TESTOSTERONE CYPIONATE INJ

## Products Affected

- Testosterone Cypionate INJ
  100MG/ML, 200MG/ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gender Dysphoria |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TESTOSTERONE ENANTHATE INJ

## Products Affected

- Testosterone Enanthate INJ

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gender Dysphoria |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 4) Requested drug is being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 5) Requested drug is being prescribed for delayed puberty OR 6) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TETRABENAZINE

## Products Affected

- Tetrabenazine

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For treatment of chorea associated with Huntington's disease: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy. For treatment of tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine or valbenazine therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# THALOMID

## Products Affected

- Thalomid

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, human immunodeficiency virus (HIV)-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TIBSOVO

## Products Affected

- Tibsovo

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation, 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-remission therapy following response to previous lower intensity therapy with the same regimen, OR 3) patient has relapsed or refractory AML. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TOBRAMYCIN

## Products Affected

- Tobramycin NEBU 300MG/5ML

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-cystic fibrosis bronchiectasis |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# TOPICAL DOXEPIN

## Products Affected

- Doxepin Hydrochloride CREA

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has experienced an inadequate response to a topical corticosteroid or topical tacrolimus. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 1 month |
| **Other Criteria** | N/A |

# TOPICAL LIDOCAINE

## Products Affected

- Lidocaine OINT 5%
- Lidocaine Hcl EXTERNAL SOLN 4%
- Lidocaine/prilocaine CREA

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# TOPICAL TESTOSTERONES

## Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone GEL 10MG/ACT, 25MG/2.5GM, 50MG/5GM
- Testosterone SOLN
- Testosterone Pump GEL 1%
- Testosterone Topical Solution

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Gender Dysphoria |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) Request is for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.] and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TOPICAL TRETINOIN

## Products Affected

- Avita
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump

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

# TOREMIFENE

## Products Affected

- Toremifene Citrate

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia. |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TRELSTAR

## Products Affected

- Trelstar Mixject INJ 11.25MG, 3.75MG

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

# TREPROSTINIL INJ

## Products Affected

- Treprostinil

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# TRODELVY

## Products Affected

- Trodelvy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent triple-negative breast cancer |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TRUSELTIQ

## Products Affected

- Truseltiq

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

# TUKYSA

## Products Affected

- Tukysa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastasis, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TURALIO

## Products Affected

- Turalio

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

# TYKERB

## Products Affected

- Lapatinib Ditosylate
- Tykerb

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Metastatic CNS lesions from HER2-positive breast cancer, recurrent EGFR-positive chordoma, HER2-amplified colorectal cancer in combination with trastuzumab. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# TYMLOS

## Products Affected

- Tymlos

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) |
| **Other Criteria** | Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. |

# UBRELVY

## Products Affected

- Ubrelvy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The patient has experienced an inadequate treatment response to one triptan 5-HT1 receptor agonist, OR 2) The patient has experienced an intolerance to one triptan 5-HT1 receptor agonist, OR 3) The patient has a contraindication that would prohibit a trial of triptan 5-HT1 receptor agonists. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# UKONIQ

## Products Affected

- Ukoniq

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

# VALCHLOR

## Products Affected

- Valchlor

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VALTOCO

## Products Affected

- Valtoco

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 6 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year. |
| **Other Criteria** | N/A |

# VELCADE

## Products Affected

- Bortezomib
- Velcade

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, pediatric acute lymphoblastic leukemia. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VELTASSA

## Products Affected

- Veltassa

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The patient has experienced an inadequate treatment response or intolerance to Lokelma OR 2) The patient has a contraindication that would prohibit a trial of Lokelma. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VENCLEXTA

## Products Affected

- Venclexta
- Venclexta Starting Pack

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For AML, any of the following criteria must be met: 1) the patient is 60 years of age or older OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy OR 4) the requested drug will be used for relapsed or refractory disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VENTAVIS

## Products Affected

- Ventavis

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# VERSACLOZ

## Products Affected

- Versacloz

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

# VERZENIO

## Products Affected

- Verzenio

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VIGABATRIN

## Products Affected

- Vigabatrin
- Vigadrone

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For complex partial seizures (CPS): patient had an inadequate response to at least 2 antiepileptic drugs for CPS. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VITRAKVI

## Products Affected

- Vitrakvi

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

# VIZIMPRO

## Products Affected

- Vizimpro

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced non-small cell lung cancer (NSCLC) |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For non-small cell lung cancer (NSCLC), the patient meets all of the following: 1) the disease is recurrent, advanced or metastatic, and 2) the member has sensitizing EGFR mutation-positive disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VORICONAZOLE

## Products Affected

- Voriconazole INJ
- Voriconazole SUSR

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 6 months |
| **Other Criteria** | The patient will be using the requested drug orally or intravenously. |

# VOSEVI

## Products Affected

- Vosevi

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). |
| **Required Medical Information** | For chronic hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Criteria will be applied consistent with current AASLD-IDSA guidance. |
| **Other Criteria** | N/A |

# VOTRIENT

## Products Affected

- Votrient

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, e) extremity/superficial trunk, head/neck sarcoma, f) solitary fibrous tumor or hemangiopericytoma, or g) alveolar soft part sarcoma (ASPS) |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# VRAYLAR

## Products Affected

- Vraylar

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# WELIREG

## Products Affected

- Welireg

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

# XALKORI

## Products Affected

- Xalkori

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, brain metastases from NSCLC, inflammatory myofibroblastic tumors (IMT), anaplastic large cell lymphoma (ALCL) |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC, the requested drug is used in any of the following settings: 1) the member has recurrent, advanced or metastatic ALK-positive NSCLC (including brain metastases from NSCLC), 2) the member has recurrent, advanced or metastatic ROS-1 positive NSCLC (including brain metastases from NSCLC), or 3) the member has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT and ALCL: the disease is ALK-positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# XELJANZ

## Products Affected

- Xeljanz
- Xeljanz Xr

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Inadequate response, intolerance or contraindication to a tumor necrosis factor (TNF) blocker. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# XGEVA

## Products Affected

- Xgeva

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Systemic mastocytosis related osteopenia or osteoporosis |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# XIFAXAN

## Products Affected

- Xifaxan TABS 550MG

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) The patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug OR 5) The patient has not previously received treatment with the requested drug. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Reduction in risk of overt HE recurrence: 6 months, IBS-D: 14 days |
| **Other Criteria** | N/A |

# XOLAIR

## Products Affected

- Xolair

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy. |
| **Age Restrictions** | For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. For nasal polyps: 18 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Allergic asthma and nasal polyps: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year. |
| **Other Criteria** | N/A |

# XOSPATA

## Products Affected

- Xospata

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# XPOVIO

## Products Affected

- Xpovio
- Xpovio 100 Mg Once Weekly
- Xpovio 40 Mg Once Weekly
- Xpovio 40 Mg Twice Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly

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

# XTANDI

## Products Affected

- Xtandi

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

# XYREM

## Products Affected

- Xyrem

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | 1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) The diagnosis has been confirmed by sleep lab evaluation AND 3)The patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, or methylphenidate) [Note: Coverage of amphetamines and methylphenidates may require prior authorization.] AND 4) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) [Note: coverage of armodafinil may require prior authorization.] OR 5) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy AND 6) The diagnosis has been confirmed by sleep lab evaluation. |
| **Age Restrictions** | 7 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. |

# YERVOY

## Products Affected

- Yervoy

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | Brain metastases from melanoma, small cell lung cancer, non-small cell lung cancer in disease with tumor mutational burden, uveal melanoma. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For small cell lung cancer, all of the following criteria must be met: 1) the requested drug is used as subsequent therapy, and 2) disease is primary progressive. For non-small cell lung cancer, the patient has either of the following: 1) the requested drug will be used for disease with tumor mutational burden (TMB), or 2) the requested drug will be used as first-line therapy for metastatic or recurrent disease with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations. For malignant pleural mesothelioma, the patient meets either of the following: 1) the requested drug will be used as first-line therapy in combination with nivolumab, OR 2) the requested drug is used as subsequent therapy. For uveal melanoma, disease is distant and metastatic. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZEJULA

## Products Affected

- Zejula

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | In combination with bevacizumab for persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer for platinum-sensitive disease. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZELBORAF

## Products Affected

- Zelboraf

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), and colorectal cancer. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For cutaneous melanoma, all of the following criteria must be met: 1) tumor is positive for BRAF V600E or V600K mutation, and 2) disease is unresectable or metastatic. For Erdheim-Chester Disease, tumor is positive for BRAF V600E or BRAF V600K mutation. For non-small cell lung cancer all of the following criteria must be met: 1) tumor is positive for the BRAF V600E mutation, and 2) patient has recurrent, advanced, or metastatic NSCLC. For thyroid carcinoma, all the following criteria must be met: 1) tumor is positive for BRAF V600E or V600K mutation, and 2) patient has radioiodine refractory follicular, Hurthle cell, or papillary thyroid carcinoma. For colorectal cancer, all of the following criteria must be met: 1) tumor is BRAF V600E mutation positive, 2) disease is unresectable or metastatic. For hairy cell leukemia: the requested drug will be used for subsequent therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZEPZELCA

## Products Affected

- Zepzelca

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

# ZOLINZA

## Products Affected

- Zolinza

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Mycosis fungoides, Sezary syndrome. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZYDELIG

## Products Affected

- Zydelig

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma]. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | N/A |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZYKADIA

## Products Affected

- Zykadia TABS

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications, Some Medically accepted Indications. |
| **Off-Label Uses** | Recurrent or advanced anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic repressor of silencing (ROS-1)-positive non-small cell lung cancer (NSCLC), inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For NSCLC: the member has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the member has ALK-positive NSCLC |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# ZYPREXA RELPREVV

## Products Affected

- Zyprexa Relprevv

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off-Label Uses** | N/A |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Tolerability with oral olanzapine has been established. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | N/A |

# PART B VERSUS PART D

## Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Ambisome
- Aminosyn II INJ 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Amphotericin B INJ
- Aprepitant CAPS
- Azathioprine INJ
- Azathioprine TABS 50MG
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cladribine
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5

- Clinimix 8/10
- Clinimix 8/14
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML
- Cytarabine Aqueous
- Dextrose 50%
- Dextrose 70%
- Diphtheria/tetanus Toxoids Adsorbed Pediatric
- Emend SUSR
- Engerix-b
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gamastan
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hcl TABS

- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Humulin R U-500 (concentrated)
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 4MG/ML
- Hydromorphone Hydrochloride INJ 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML
- Imovax Rabies (h.d.c.v.)
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Khapzory
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride
- Melphalan
- Methylprednisolone TABS
- Methylprednisolone Acetate INJ 40MG/ML, 80MG/ML
- Methylprednisolone Sodium Succinate
- Methylprednisolone Sodiumsuccinate INJ 125MG, 40MG
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 1MG/ML, 25MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nephramine
- Nulojix

- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prednisolone SOLN
- Prednisolone Sodium Phosphate ORAL SOLN 10MG/5ML, 15MG/5ML, 20MG/5ML, 25MG/5ML, 5MG/5ML
- Prednisolone Sodium Phosphate Odt
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG, 2.5MG, 20MG, 50MG, 5MG
- Prednisone Intensol
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Procalamine
- Prograf PACK
- Prosol
- Rabavert
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS

- Tdvax
- Tenivac
- Tpn Electrolytes INJ 29.5MEQ/20ML; 4.5MEQ/20ML; 35MEQ/20ML; 5MEQ/20ML; 20MEQ/20ML; 35MEQ/20ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 97MEQ/L; 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ
- Zortress

## Details

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

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