2022 2 Tier Standard - Amerihealth Caritas VIP Care

2022 Prior Authorization Criteria

CURRENT AS OF 07/01/2022

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented adequate trials and/or has another documented medical reason for not using at least 2 of the treatment options listed: topical steroids, Tazorac (tazarotene), methotrexate, and cyclosporine.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ACTEMRA

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For sJIA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ADEFOVIR

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and IV classification and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	1) Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micrometer/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease. AND 2) If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin, the patient has a documented medical reason (such as trial, intolerance or contraindication) for not using Prolastin to treat their medical condition.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

APOKYN

Products Affected

- *apomorphine hcl subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient must have a documented trial of, contraindication to, or medical reason for not using two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ARCALYST

Products Affected
- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ARIPIPRAZOLE LONG ACTING

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- ARISTADA INITIO
- ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BANZEL

Products Affected

- *rufinamide oral suspension*
- *rufinamide oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	History of familial Short QT syndrome
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one formulary alternative generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist, nephrologist, or specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts: 6 months. Cont of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts for systemic lupus erythematosus (SLE): trial of two of the following glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine, chloroquine, and cyclophosphamide. For continuation of therapy or reauthorization for SLE: documentation of clinical response to therapy (i.e. fewer flares that required steroid treatment, lower average daily oral prednisone dose, improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits, etc. For new starts for lupus nephritis (LN): concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization for LN: Documentation of improvement in renal function (i.e. reduction in UPCR).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BENZNIDAZOLE

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Exclusion Criteria	Patients who have used disulfiram within two weeks of initiation of benznidazole
Required Medical Information	Patient has not used disulfiram within two weeks prior to benznidazole initiation per claims history for existing members or attestation from provider for members new to the health plan.
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 80 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or specialist for submitted diagnosis.
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOSENTAN

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BUDESONIDE ER 9 MG

Products Affected

- *budesonide er oral tablet extended release 24 hour*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	Patient must have a documented trial of, contraindication to, or medical reason for not using sulfasalazine, balsalazide, or an oral mesalamine product.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

C1 ESTERASE INHIBITOR

Products Affected

- CINRYZE
- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an allergist, immunologist, rheumatologist, or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CARBAGLU

Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CASPOFUNGIN

Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status.
Required Medical Information	Patient's CYP2D6 metabolizer status, as determined by an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For reauthorization, documentation has been provided that patient has obtained clinical benefit from medication (e.g. increased platelet count, improvement in anemia, PFTs, improvement in radiographic scans, improved quality of life).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CGRP ANTAGONISTS

Products Affected

- AIMOVIG
- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for migraine prophylaxis: 1) at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs) and 2) trial of, contraindication to, or medical reason for not using at least two of the following agents: a beta adrenergic blocker, an anti-epileptic agent, a tricyclic antidepressant, or a serotonin-norepinephrine reuptake inhibitor. For continuation of therapy or reauthorization for migraine prophylaxis (after 6 month start): reduction of at least 1 headache day per month from baseline. New starts on Emgality for episodic cluster headache: trial of, contraindication to, or medical reason for not using verapamil for at least 4 weeks at minimum effective doses. For continuation of therapy or reauthorization for Emgality for episodic cluster headache: reduction in the frequency of headaches (clinical benefit).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CHOLBAM

Products Affected
- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist or gastroenterologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CIBINQO

Products Affected

- CIBINQO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For atopic dermatitis: trial of, contraindication to, or medical reason for not using Rinvoq.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CIMZIA

Products Affected

- CIMZIA PREFILLED SUBCUTANEOUS PREFILLED SYRINGE KIT
- CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: approve. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication to Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.

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

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one formulary alternative generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) LVEF of 35% or less 2) Sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) Blood pressure greater than or equal to 90/50 mmHg, and 4) Trial of, contraindication to, or medical reason for not receiving a beta blocker.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CORTROPHIN

Products Affected

- CORTROPHIN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COSENTYX

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML
- *cosentyx subcutaneous solution prefilled syringe 75 mg/0.5ml*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For nonradiographic axial spondyloarthritis: approve. For enthesitis-related arthritis: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CYSTAGON

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DALFAMPRIDINE ER

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure or moderate/severe renal impairment (CrCl 50 mL/min or less).
Required Medical Information	For new starts: 1) Attestation that creatinine clearance (CrCl) greater than 50 mL/min was confirmed prior to initiation of therapy, AND 2) Documentation has been provided that member is ambulatory (able to walk at least 25 feet) and has a documented walking impairment, AND 3) For appropriate indications, member is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc.) or has a medical reason why member is unable to use a disease modifying agent for their condition. For continuation of therapy or re-authorization requests: 1) Member must experience improvement in walking from baseline due to use of dalfampridine ER.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DEFERASIROX

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with GFR less than 40 mL/min/1.73 m(2) or patients with platelet counts less than 50,000/mm3.
Required Medical Information	For all indications: platelet count greater than 50,000/mm3 (within 30 days) and GFR greater than 40 mL/min/1.73 m(2). For chronic iron overload due to transfusions: serum ferritin concentration greater than 1000 mcg/L (lab result with 30 days). For chronic iron overload in non-transfusion-dependent thalassemia syndromes: serum ferritin concentration greater than 300 mcg/L (lab result with 30 days).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For deferasirox granules oral packets or deferasirox oral soluble tablets, trial of, contradiction to, or medical reason for not using deferasirox tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DEPEN

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira. For other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DIACOMIT

Products Affected
- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DIFICID

Products Affected

- DIFICID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 10 days.
Other Criteria	Documentation of prior use, or a medical reason for being unable to use oral vancomycin for current infection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DOPTELET

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for chronic liver disease and chronic immune thrombocytopenia (chronic ITP): documented baseline platelet count of less than 50,000/mcL.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hematologist, hepatologist or surgeon.
Coverage Duration	For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DOXEPIN CREAM

Products Affected

- *doxepin hcl external*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of trial of, contraindication to, or medical reason for not using a topical corticosteroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. New starts for asthma with eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter, and 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. New starts for oral corticosteroid asthma: symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment, (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal corticosteroids. Continuation of therapy or reauthorization for all indications: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EGRIFTA

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EMPAVELI

Products Affected

- EMPAVELI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, nephrologist, oncologist, or other appropriate specialist.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts, all of the following must be provided: 1) Documentation of vaccination against meningococcal disease or a documented medical reason why the patient cannot receive vaccination or vaccination needs to be delayed, 2) Documentation that antimicrobial prophylaxis with oral antibiotics (such as penicillin, macrolides, ciprofloxacin, etc.) for two weeks has been provided if the meningococcal vaccine is administered less than 2 weeks before starting therapy or a documented medical reason why the patient cannot receive oral antibiotic prophylaxis, 3) Documentation of diagnosis by high sensitivity flow cytometry, AND 4) Documentation of Hemoglobin (Hgb) less than 10.5 g/dL. For continuation of therapy or reauthorization, documentation of clinical response to therapy (e.g., increased Hgb, reduced need for blood transfusions, improvement in quality of life scores).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For PsA or psoriasis: approve. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that two or more painful sickle cell crises have occurred in the past 12 months. Trial of, contraindication to, or medical reason for not using hydroxyurea for at least three months.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EPRONTIA

Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	Documented trial of, contraindication to, or medical reason for not using topiramate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERYTHROPOETIN STIMULATING AGENTS

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for all indications: Hgb less than 10 g/dL or within compendia range for treatment of the requested medical condition. If the request for Epogen, Procrit, or Aranesp, trial of, contraindication to, or medical reason for not using Retacrit for appropriate indications. For continuation of therapy or re-authorization: Hgb must not exceed 10 g/dL (anemia related to cancer), 11 g/dL (anemia of CKD), 12 g/dL (zidovudine-related anemia in members with HIV and ribavirin-induced anemia), 13 g/dL (elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ESBRIET

Products Affected

- ESBRIET
- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of idiopathic pulmonary fibrosis: documentation of confirmation of diagnosis on high resolution CT scan or through lung biopsy.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EUCRISA

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using topical tacrolimus or pimecrolimus.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For continuation of therapy or reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening, patient remains permanent ventilation free if no prior ventilator support).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma with an eosinophilic phenotype: 1) blood eosinophil count greater than or equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months, AND 2) symptoms persist with at least 1 exacerbation in the last 12 months requiring additional treatment (e.g. oral systemic steroids) while on a high dose inhaled corticosteroid with a long-acting B2 agonist. Continuation of therapy or re-authorization for severe asthma with an eosinophilic phenotype: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FENTANYL CITRATE TRANSMUCOSAL PRODUCTS

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation must be provided for the all of the following: 1) fentanyl citrate oral transmucosal is being prescribed to treat cancer-related breakthrough pain AND 2) Patient has been taking opioids at a dose equal to 60 MME per day for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FERRIPROX

Products Affected

- *deferiprone*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts: 1) serum ferritin level above 1,000 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request, and 2) Trial of, contraindication to, or medical reason for not using deferasirox tablets. For continuation of therapy or reauthorization, decrease in serum ferritin from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using one formulary generic anticonvulsant for appropriate indications.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FIRDAPSE

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a gastroenterologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GNRH AGONISTS

Products Affected

- ELIGARD
- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard, the patient must have a documented trial of, contraindication to, or medical reason for not using Eligard to treat their prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts: trial of, contraindication to, or medical reason for not using generic amantadine. Continuation of therapy or reauthorization: Member demonstrates clinical benefit (i.e. improvement in levodopa-induced dyskinesia or decreased off episodes).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GROWTH HORMONES

Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED
- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for growth hormone deficiency: 1) If the request is not for Genotropin, trial of, contraindication to, or medical reason for not using Genotropin, 2) documentation showing bone age testing, height, weight, and Growth Hormone Stimulation Test results OR Insulin Growth Factor 1 level. For continuation of therapy or reauthorization for growth hormone deficiency: documentation (medical records) showing positive response to treatment. For requests for all other medically accepted indications other than growth hormone deficiency, the request will be approved for products other than Skytrofa.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

H. P. ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts for MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, edematous state (e.g. nephrotic syndrome without uremia), and respiratory diseases: trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for ophthalmic disease: trial of, contraindication to, or medical reason for not using oral or ophthalmic corticosteroids. Continuation of therapy or reauthorization for MS exacerbation: documentation of symptom improvement and current use of a multiple sclerosis disease modifying agent for maintenance therapy. Continuation of therapy or reauthorization for all other conditions: documented evidence of response to treatment and symptom improvement.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	MS exacerbation: 1 month. Other conditions: new start for 3 months and reauth end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HETLIOZ

Products Affected

- HETLIOZ
- HETLIOZ LQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH DOSE OPIOID

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr*
- *methadone hcl oral tablet 10 mg*
- *morphine sulfate er oral tablet extended release 100 mg, 200 mg*
- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be approved. For new starts, ALL of the following are required: (1) Taking opioids at a dose equal to 60 MME per day for at least one week, (2) Current regimen is the lowest possible effective dose of opioid therapy, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

HIGH RISK MEDICATION

Products Affected

- *clemastine fumarate oral tablet 2.68 mg*
- *cyproheptadine hcl oral*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *ergoloid mesylates oral*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg*
- *glyburide-metformin oral tablet 5-500 mg*
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet 25 mg, 50 mg*
- *hydroxyzine pamoate oral*
- *indomethacin er*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml*
- *meperidine hcl oral solution*
- *meperidine hcl oral tablet 50 mg*
- *methyldopa oral*
- *nifedipine oral*
- NORPACE CR
- *pentazocine-naloxone hcl*
- *promethazine hcl oral*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine vc*
- *promethazine-phenylephrine*
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

HIGH RISK MEDICATION - PROTECTED CLASS DRUGS

Products Affected

- *amitriptyline hcl oral*
- *amoxapine*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *megestrol acetate oral tablet*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *perphenazine-amitriptyline*
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*
- *protriptyline hcl*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATION, BUTALBITAL

Products Affected

- ASCOMP-CODEINE
- BAC
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-asa-caffeine*
- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATION, DIGOXIN

Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, 2) the risks and side effects have been discussed and will be monitored, and 3) trial of or medical reason for not using digoxin doses up to 0.125 mg per day.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

Products Affected

- *carisoprodol oral*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 30 days. Continuation of therapy or reauth will be for 90 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATION, SLEEP AGENTS

Products Affected

- *eszopiclone*
- *temazepam*
- *zaleplon*
- *zolpidem tartrate er*
- *zolpidem tartrate oral tablet 10 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older the prescriber has documented: 1) the benefits of treatment with the drug outweigh the potential risks identified for people 65 years old and older, and 2) the risks and side effects have been discussed and will be monitored. For zolpidem immediate release 10mg and zolpidem ER: trial of or medical reason for not using zolpidem immediate release 5mg.
Age Restrictions	Prior authorization only applies to members 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PEDIATRIC UC START
- HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA PEN-PSOR/UVEIT STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen. For Crohns Disease: Trial of, medical reason for not using, or contraindication to 1 of the following: mercaptopurine, azathioprine, or corticosteroid (e.g., prednisone, methylprednisolone). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone). For PsA, psoriasis, Hidradenitis Suppurativa, or Uveitis: approve.

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

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an immunologist, allergist, rheumatologist, or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ILARIS

Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sJIA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ILUMYA

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pediatric endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTRON-A

Products Affected
- INTRON A

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INVEGA TRINZA

Products Affected

- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented treatment with Invega Sustenna for at least 4 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	New starts: trial of, contraindication to, or medical reason for not using acetazolamide. Continuation of therapy or reauthorization: documentation of clinical improvement with therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, neurologist, or endocrinologist.
Coverage Duration	New starts will be authorized for 2 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KEVZARA

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus.
Required Medical Information	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus or tacrolimus concurrently with Korlym.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KYNMOBI

Products Affected

- KYNMOBI

PA Criteria	Criteria Details
Exclusion Criteria	Kynmobi (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. For Parkinsons: trial of, contraindication to, or medical reason for not using two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LAMPIT

Products Affected

- LAMPIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 90 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIVMARLI

Products Affected

- LIVMARLI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Trial of, contraindication to, or medical reason for not using both of the following: cholestyramine AND rifampin. 2) Prescriber attests that the member has cholestasis 3) Baseline serum bile acid level is provided. 4) Documentation of patients weight. For continuation of therapy or reauthorization: 1) Documentation submitted indicating the member has had all of the following: an improvement in pruritis (e.g. improved observed scratching, decreased sleep disturbances/nighttime awakenings due to scratching, etc.) AND reduction in serum bile acid level from baseline. 2) Prescriber attests that patient has had no evidence of hepatic decompensation (e.g. variceal hemorrhage, ascites, hepatic encephalopathy, portal hypertension, etc.). 3) Documentation of patients weight.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUCEMYRA

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For initial therapy, patient must have documented trial of, contraindication to, or medical reason for not using clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with cyclophosphamide.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be rheumatologist, nephrologist, or other specialist in the treatment of autoimmune disorders.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: 1) Documentation of urine protein/creatinine ratio (UPCR), 2) Documentation that the member has a baseline eGFR greater than 45 mL/min/1.73m2 or that benefit outweighs risk of using this medication at current eGFR, and 3) Concurrent use of or medical reason for not using background immunosuppressive therapy regimen. For continuation of therapy or reauthorization: Documentation of improvement in renal function (i.e. reduction in UPCR or no confirmed decrease from baseline eGFR greater than or equal to 20%).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LYBALVI

Products Affected

- *lybalvi*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with opioids.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	1) Attestation from the provider that the member has had an opioid-free period of a minimum of 7 days after last use of shorting-acting opioids and 14 days from last use of long-acting opioids before initiating Lybalvi, AND 2) Documented trial of, contraindication to, or medical reason for not using at least two generic antipsychotics, one of which must be generic olanzapine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAVYRET

Products Affected

- *mavyret oral packet*
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Labs within 3 months of request: liver function tests, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

METHOXSALEN

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

METYROSINE

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of one of the following: 1) Concurrent use of alpha adrenergic blockers, 2) Medical reason for being unable to use an alpha adrenergic blocker, OR 3) Patient is not a candidate for surgical resection and requires long term treatment with metyrosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts, documentation of diagnosis for mild to moderate type 1 Gaucher disease. For continuation of therapy or reauthorization: documentation of clinical benefit from use of the drug (i.e. increased platelet count, improvement in anemia, PFT's, improvement in radiographic scans, improved quality of life).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a specialist in treatment of Gaucher's disease.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS AGENTS

Products Affected

- AUBAGIO
- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack*
- EXTAVIA SUBCUTANEOUS KIT
- GILENYA ORAL CAPSULE 0.5 MG
- *glatiramer acetate*
- GLATOPA
- KESIMPTA
- MAYZENT
- MAYZENT STARTER PACK
- PONVORY
- PONVORY STARTER PACK
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	If the medication request is for glatiramer, Glatopa, or dimethyl fumarate, the request will be approved. If the request is not for glatiramer, Glatopa, or dimethyl fumarate for multiple sclerosis, the member must have a documented trial of, contraindication to or a medical reason for not using both dimethyl fumarate AND glatiramer or Glatopa. If the request is for Zeposia for ulcerative colitis: Either 1) Trial of, medical reason for not using, or contraindication Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

MYFEMBREE

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Patient has history of osteoporosis or hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an obstetrician-gynecologist.
Coverage Duration	New starts: 6 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: Trial of, contraindication to, or medical reason for not using an estrogen-progestin contraceptive therapy. For new starts if one of the following drugs has been tried previously, a trial of estrogen-progestin contraceptive therapy is not required: gonadotropin-releasing hormone (GnRH) agonists or tranexamic acid. For continuation of therapy or reauthorization both of the following are required: 1) Treatment does not exceed the eligible maximum lifetime treatment duration of 2 years, and 2) Documentation has been provided that the member has obtained clinical benefit from medication (e.g. reduced menstrual bleeding from baseline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NASAL ANTISEIZURE AGENTS

Products Affected

- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Provider attests that diazepam rectal gel cannot be used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	N/A
Prescriber Restrictions	Provider is an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin 3) Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the patient is not able to tolerate ezetimibe AND 4) Member will continue on maximum tolerated statin dose and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from

PA Criteria	Criteria Details
	baseline) AND 2) Member will continue on maximum tolerated statin and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin, AND 3) Member will continue on maximum tolerated statin dose while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the new start is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm, AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For continuation of therapy or reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline), AND 2) Member will continue on maximum tolerated statin while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin.

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

NITISINONE

Products Affected

- *nitisinone*
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NITYR

Products Affected

- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, metabolic specialist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NOXAFIL

Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis: trial of, contraindication to, or medical reason for not using fluconazole or itraconazole. For prophylaxis of invasive aspergillus infections due to being severely immunocompromised: trial of, contraindication to, or medical reason for not using voriconazole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for severe asthma: 1) blood eosinophil count greater than or equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months, AND 2) symptoms with equal to or greater than 1 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids) while on a high-dose inhaled corticosteroid with a long-acting B2 agonist. New starts for eosinophilic granulomatosis with polyangiitis (EGPA): trial of, contraindication to, or medical reason for not using one of the following medications: cyclophosphamide or methotrexate. New starts for hypereosinophilic syndrome without an identifiable non-hematologic secondary cause: 1) 2 or more flares within the past 12 months AND 2) trial of, contraindication to, or medical reason for not using oral corticosteroids. New starts for chronic rhinosinusitis with nasal polyps: trial of, contraindication to, or medical reason for not using nasal corticosteroids. Continuation of therapy or re-authorization for all indications: clinical benefit from use of the drug.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Complete atrioventricular (AV) block without implanted pacemaker, or at high risk of complete AV block. History of heart failure. Concomitant use with MAOIs or use of MAOIs within 14 days. Concomitant use with drugs containing quinidine, quinine, or mefloquine. History of quinine-, mefloquine-, dextromethorphan/quinidine-, or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome. Non-Part D indications.
Required Medical Information	Confirmation diagnosis is for Part D indication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NURTEC

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist or pain specialist.
Coverage Duration	New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts for acute treatment of migraines: trial of, contraindication to, or medical reason for not using 2 triptans. For new starts for prevention of episodic migraine: trial of, contraindication to, or medical reason for not using Emgality or Aimovig. For continuation of therapy or reauthorization requests: documentation of improvement in pain and symptom(s) (e.g., photophobia, nausea, phonophobia).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Members with complete biliary obstruction.
Required Medical Information	For new starts: 1) Attestation that the member has failed at least a 12 month trial of ursodiol, or has a medical reason (e.g. intolerance, hypersensitivity) for being unable to tolerate ursodiol AND 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), and bilirubin within 90 days of request. For continuation of therapy or reauthorization: Documentation that that the member has responded to Ocaliva (e.g. improved biochemical markers (e.g., ALP, bilirubin, GGT, AST, ALT levels)).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of idiopathic pulmonary fibrosis: 1) Documentation of disease as demonstrated on a high resolution CT scan or through lung biopsy and 2) Documented trial of, contraindication to, or medical reason for not using Esbriet. For a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD): documented trial of, contraindication to, or medical reason for not using mycophenolate mofetil or cyclophosphamide. For a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype: documentation is provided confirming diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or lung transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OLUMIANT

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following: Enbrel, Humira, Rinvoq, or Xeljanz, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORAL ANTINEOPLASTIC AGENTS

Products Affected

- *abiraterone acetate*
- ALECENSA
- ALUNBRIG
- AYVAKIT
- BALVERSA
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- EXKIVITY
- FOTIVDA
- GAVRETO
- GILOTRIF
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate*
- IMBRUVICA
- INLYTA
- INQOVI
- INREBIC
- IRESSA
- JAKAFI
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)
- KOSELUGO
- *lapatinib ditosylate*
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- MEKINIST
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- ONUREG
- ORGOVYX
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- QINLOCK
- RETEVMO
- REVLIMID ORAL CAPSULE 2.5 MG, 20 MG
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX

- SPRYCEL
- STIVARGA
- *sunitinib malate*
- TABLOID
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG
- *talzenna oral capsule 0.5 mg, 0.75 mg*
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID
- TIBSOVO
- *toremifene citrate*
- *truseltiq (100mg daily dose)*
- *truseltiq (125mg daily dose)*
- *truseltiq (50mg daily dose)*
- *truseltiq (75mg daily dose)*
- TUKYSA
- TURALIO
- UKONIQ
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- VOTRIENT
- *welireg*
- XALKORI
- XOSPATA
- 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)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For new starts of Jakafi and Imbruvica for treatment of graft-versus-host disease (GVHD): documented trial of, contraindication to, or medical reason for not using a systemic corticosteroid. For continuation of therapy of Jakafi and Imbruvica for treatment of Graft-Versus-Host Disease

PA Criteria	Criteria Details
	(GVHD): documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose). For Jakafi and Imbruvica for all other indications, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORAL ANTIPSYCHOTICS

Products Affected

- CAPLYTA
- FANAPT
- FANAPT TITRATION PACK
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For schizophrenia and manic or mixed episodes associated with bipolar l disorder: trial of, contraindication to, or medical reason for not using one formulary generic antipsychotic. For major depressive disorder associated with bipolar l or II disorder: trial of, contraindication to, or medical reason for not using two formulary generic antipsychotics.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For pJIA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For acute graft versus host disease: attestation member is taking in combination with a calcineurin inhibitor and methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORILISSA

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	Patient has osteoporosis or severe hepatic impairment.
Required Medical Information	Trial of, contraindication to, or medical reason for not using the following concurrently for endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For reauthorization, continued benefit with use of the drug.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an OB/GYN.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to lumacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORLADEYO

Products Affected

- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an allergist, immunologist, rheumatologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OXBRYTA

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts: Baseline labs have been submitted for the following: Hemoglobin (Hb), Indirect bilirubin, Reticulocytes. Documentation was provided that the member has had 1 or more pain crises in the last 12 months. Member has a baseline Hb level less than 10.5 g/dL. Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea). For Oxbryta soluble tablets, medical reason for not using Oxbryta tablets. Continuation of therapy or reauthorization: Documentation submitted indicates clinical benefit at 6 months from initiation, and continued clinical benefit at subsequent 12-month intervals defined as the following: Documentation of one of the following: Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter) Or documentation of reduced number of vaso-occlusive/pain crises since Oxbryta was started Or documentation of one of the following: Decrease in indirect bilirubin from baseline Or decrease in percentage of reticulocytes from baseline.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an ophthalmologist.
Coverage Duration	Request will be authorized for 8 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OXYCODONE ER

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Members being treated for active cancer diagnoses, sickle cell diagnoses, those in hospice care, or receiving palliative care will be excluded from the concurrent benzodiazepine and muscle relaxant therapy requirement. For new starts, ALL of the following are required: (1) Member has documented history of receiving an immediate-release opioid, (2) Member has a documented trial of or intolerance to long-acting morphine sulfate, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products. For continuing therapy, ALL of the following are required: (1) Member's pain has been assessed within the last 6 months, (2) Member has demonstrated clinical improvement in pain and function on current medication regimen, (3) If member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber attests that concurrent therapy is medically necessary, (4) Member is not being treated for substance abuse with buprenorphine-containing products.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PALIPERIDONE

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For schizophrenia: trial of, contraindication to, or medical reason for not using an alternative generic formulary second generation atypical antipsychotic.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PCSK9 INHIBITORS

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	New starts will be authorized for 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For ALL diagnoses (including primary hyperlipidemia) for new starts: 1) documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies, and 2) If patient experiences statin intolerance, trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. For familial hypercholesterolemia (FH), TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis, 2) clinical manifestations of FH such as xanthomas or inflamed tendons, 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (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). For ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other

PA Criteria	Criteria Details
	arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for continuation of therapy or reauthorization: repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from new start.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PEGINTERFERON

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- *pegasys subcutaneous solution prefilled syringe*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C: 1) Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. 2) Documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: 1) Labs within 3 months of request: ALT/AST, and 2) HBeAg status.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for 24 to 48 weeks as defined by compendia.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PENTAMIDINE SOLUTION FOR INJECTION

Products Affected

- *pentamidine isethionate injection*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PERSERIS

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Trial of, contraindication to, or medical reason for not using doxazosin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PRETOMANID

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Required Medical Information	Documentation of use in combination with bedaquiline and linezolid. Laboratory confirmed pulmonary MDR-TB resistant to isoniazid and rifampin
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 26 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PROLIA

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than - 2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: trial of, contraindication to, or medical reason for not using an oral bisphosphonate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PROMACTA

Products Affected

- PROMACTA ORAL PACKET
- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For chronic immune (idiopathic) thrombocytopenia (ITP): 1) Documented baseline platelet count less than 30,000 cells/ microL AND 2) Trial of, medical reason for not using, or contraindication to glucocorticosteroids. For severe aplastic anemia: 1) Prescribed with at least one formulary immunosuppressive agent OR trial of, contraindication to, or medical reason for not using one, AND 2) Documentation of baseline platelet count less than 20,000 cells/microL OR platelet count less than 30,000 cells/microL with bleeding OR reticulocyte count less than 20,000 cells/microL OR absolute neutrophil count less than 500 cells/microL. For thrombocytopenia in patients with Hepatitis C infection: documented baseline platelet count less than 50,000 cells/microL.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PYRUKYND

Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: 1) documentation of diagnosis and 2) baseline hemoglobin level. For continuation of therapy or reauthorization: documentation of clinical improvement (e.g. reduction in number of blood transfusions, or increase or stabilization in hemoglobin level). If the criteria are not met, may authorize up to 14 days of a Pyrukynd Taper Pack to allow for tapering.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.
Coverage Duration	New starts: 6 mo. Cont of therapy or reauth: end of contract yr. Denial: 14 days for dose tapering.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RECORLEV

Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using ketoconazole tablets.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized for 20 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RELISTOR

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For appropriate indications, patient must have documented trial of or medical reason for not using the following: 1) lubiprostone, AND 2) lactulose. Additionally, for constipation caused by opioids that are used for chronic, non-cancer pain, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For schizophrenia: trial of, contraindication to, or medical reason for not using one formulary generic antipsychotic. For major depressive disorder: trial of, contraindication to, or medical reason for not using to two formulary generic antidepressants.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, or other specialist in the treatment of hematopoietic cell transplants.
Coverage Duration	New starts: 3 months. Cont. of therapy or reauthorization: until end of contract year.
Other Criteria	For new starts: documented trial of, contraindication to, or medical reason for not using at least two lines of systemic immunosuppressive therapy (e.g. corticosteroids, tacrolimus, mycophenolate mofetil, Imbruvica, or Jakafi), one of which must be a systemic corticosteroid. For continuation of therapy or re-authorization: documentation of clinical benefit from use of the drug (i.e. symptom improvement, reduction in corticosteroid dose).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RINVOQ

Products Affected

- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG
- *rinvoq oral tablet extended release 24 hour 45 mg*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel or Humira). For atopic dermatitis: trial of, contraindication to, or medical reason for not using: 1)topical tacrolimus or pimecrolimus and 2) Eucrisa. For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and Humira. For ankylosing spondylitis: Trial of, medical reason for not using, or contraindication to naproxen and 1 TNF blocker (Enbrel or Humira).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYLAZE

Products Affected

- RYLAZE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, hematologist, or specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SAPROPTERIN

Products Affected

- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: documentation of elevated baseline phenylalanine levels. Continuation of therapy or reauthorization: prescriber attests the member has improvement in phenylalanine levels from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	New starts will be authorized for 3 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Trial of, contraindication to, or medical reason for not using to one formulary generic antipsychotics.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a HIV specialist.
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIGNIFOR

Products Affected
- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SILDENAFIL ORAL

Products Affected

- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation of trial of, contraindication to, or medical reason for not using sildenafil tablet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SILIQ

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Either 1) Trial of, medical reason for not using, or contraindication to 1 of the following: Enbrel or Humira or 2) If utilized within the past 120 days, approve for continuation of therapy. For PsA: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication to Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of prior trial of or medical reason for not using first-line TB regimen containing isoniazid and rifampin. Documentation (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking 3 additional antimycobacterial drugs in combination to treat MDR-TB.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- SKYRIZI
- SKYRIZI (150 MG DOSE)
- SKYRIZI PEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For psoriasis: approve. For PsA: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SODIUM PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SOFOSBUVIR/VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

STELARA

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For Crohns Disease: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For UC: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patients age) to Humira or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Trikafta.
Required Medical Information	Documentation of CFTR gene that is responsive to tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMLIN

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Patient has confirmed gastroparesis.
Required Medical Information	For new starts: HbA1C values within 90 days of request is greater than or equal to 7% despite receiving insulin therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not using two alternative formulary anti-diabetic agents.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYNDROS

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not being able to use dronabinol capsules.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TADALAFIL

Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TALTZ

Products Affected

- TALTZ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Tremfya, Xeljanz, Rinvoq, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For psoriasis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Skyrizi, Tremfya, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For ankylosing spondylitis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to 2 of the following therapies: Cosentyx, Enbrel, or Humira, or 2) If utilized within the past 120 days, approve for continuation of therapy. For non-radiographic axial spondyloarthritis: Either 1) Trial of, medical reason for not using, or contraindication (e.g., safety concerns, not indicated for patient's age) to Cosentyx, or 2) If utilized within the past 120 days, approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TARYPEYO

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts: attestation that member has 1) Diagnosis of primary immunoglobulin A nephropathy (IgAN) and 2) at risk of rapid disease progression. Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m(2) and proteinuria (defined as either greater than or equal to 1 g/day or urine protein/creatinine ratio [UPCR] greater than or equal to 1.5 g/g). For continuation of therapy: documentation that member has been on Tarpeyo for less than 9 months. For reauthorizations: Requests will not be allowed as the safety and efficacy of subsequent courses of Tarpeyo have not been established.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist.
Coverage Duration	Request will be authorized for 9 months.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or hematologist.
Coverage Duration	New starts will be authorized for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: 1) Prescriber attests that Tavneos will be prescribed in combination with corticosteroids AND cyclophosphamide unless there is documented trial of, contraindication to, or medical reason for not using these therapies. 2) Documentation of baseline Birmingham Vasculitis Activity Score (BVAS) score 3) Prescriber attestation that the patient will have liver function tests before treatment (ALT, AST, alkaline phosphate, and total bilirubin) and every 4 weeks after start of therapy for the first 6 months of treatment 4) Prescriber attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) infection at baseline. For continuation of therapy or reauthorization: 1) Documentation of remission (BVAS score of 0) OR improvement in BVAS score 2) Prescriber attestation that patient has no abnormality in liver function tests (abnormality: ALT or AST greater than 3 times the upper limit of normal and bilirubin greater than 2 times the upper limit of normal) 3) Prescriber attestation that patient has no active HBV infection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TEFLARO

Products Affected

- TEFLARO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TERIPARATIDE

Products Affected

- *teriparatide (recombinant)*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: 1) Trial of, medical reason for not using, or contraindication to an oral bisphosphonate and Prolia and 2) therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

THIOLA

Products Affected

- THIOLA EC
- *tiopronin oral*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOLVAPTAN

Products Affected

- JYNARQUE
- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A4 inhibitors (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using a strong CYP3A4 inhibitor (i.e. clarithromycin, ketoconazole, itraconazole, ritonavir, lopinavir-ritonavir, indinavir-ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, conivaptan, and telithromycin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, hepatologist, or nephrologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL ANTINEOPLASTIC RETINOIDS

Products Affected

- *panretin*
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL TESTOSTERONE

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient initiating topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two instances of low serum total or free testosterone, as defined by the reference range by the lab. For all patients, provider attests that PSA levels, hemoglobin, hematocrit and testosterone levels will be monitored periodically throughout the treatment as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRANSDERMAL LIDOCAINE

Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TREMFYA

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For PsA or psoriasis: approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRIENTINE

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Trial of, contraindication to, or medical reason for not using penicillamine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRIKAFTA

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Orkambi, or Symdeko.
Required Medical Information	Documentation of CFTR gene that is responsive to elexacaftor-tezacaftor-ivacaftor treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in the treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	The following criteria is also applicable: 1) trial of, contraindication to, or medical reason for not using an oral bisphosphonate and Prolia, and 2) therapy does not exceed 2 years.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, headache specialist or pain specialist.
Coverage Duration	New starts will be approved for 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	For new starts: trial of, contraindication to, or medical reason for not using 2 triptans. For continuation of therapy or reauthorization requests: documentation of improvement in pain and symptom(s) (e.g., photophobia, nausea, phonophobia).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UPTRAVI

Products Affected

- UPTRAVI ORAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I and PAH Functional Class. Trial of, contraindication to, or medical reason for not using a formulary phosphodiesterase inhibitor in combination with a formulary endothelin receptor antagonist.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial of, contraindication to, or medical reason for not being able to use one of the following: a topical corticosteroids or a topical retinoids.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VASCEPA

Products Affected

- *icosapent ethyl*
- VASCEPA ORAL CAPSULE 0.5 GM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For a diagnosis of hypertriglyceridemia: Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose OR documented statin intolerance AND omega-3-acid ethyl esters capsule. For a diagnosis of cardiovascular risk reduction, ALL the following are required: 1) Documentation of hypertriglyceridemia greater than or equal to 150 mg/dL: 2) Documented trial of, contraindication to, or medical reason for not using statins at maximum tolerated dose for 3 months OR documented statin intolerance AND 3) Documentation of one of the following: Established atherosclerotic cardiovascular disease (e.g., coronary artery disease, cerebrovascular accident, carotid disease, peripheral artery disease) OR age greater than or equal to 50 years old with established diabetes and at least one additional risk factor for cardiovascular disease (e.g., hypertension, renal dysfunction, retinopathy, albuminuria, males age greater than or equal to 55 years old or females age greater than or equal to 65 years old).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group I classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIGABATRIN

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For infantile spasms or West syndrome, the request will be approved. Patient must have a diagnosis of refractory complex partial seizures who is currently receiving another antiepileptic drug and the patient has experienced treatment failure from two generic alternative formulary antiepileptic agents.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VMAT-2 INHIBITORS

Products Affected

- AUSTEDO
- INGREZZA ORAL CAPSULE 40 MG, 80 MG
- *ingrezza oral capsule 60 mg*
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	If the request is for tetrabenazine, request will be approved. For Ingrezza, trial of or medical reason for not using the tetrabenazine for tardive dyskinesia. For Austedo, trial of or medical reason for not using the following if applicable for submitted diagnosis 1) Chorea associated with Huntington disease- trial of tetrabenazine. 2) Tardive dyskinesia -trial of tetrabenazine and Ingrezza. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist, clinical geneticist, or psychiatrist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	Non-Part D indications.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Labs within 3 months of request: liver function tests and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. Prescriber attests to completing HBV screening and agrees to monitor for HBV reactivation if patient has a history of HBV infection.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

WHITE BLOOD CELL STIMULATORS

Products Affected

- FULPHILA
- GRANIX
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE
- NYVEPRIA
- UDENYCA
- ZARXIO
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For new starts for Neupogen and Granix: documentation of trial of, contraindication to, or medical reason for not using Zarxio and Nivestym. For new starts for Neulasta, Fulphila, and Nyvepria: documentation of trial of, contraindication to, or medical reason for not using Udenyca and Ziextenzo. Continuation of therapy or re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	For new starts: 4 months. Cont of therapy or reauth until end of contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For RA: Trial of, medical reason for not using, or contraindication to 1 disease modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) and 1 tumor necrosis factor (TNF) blocker (Enbrel or Humira). For pJIA: Trial of, medical reason for not using, or contraindication to 1 of the following DMARDs: methotrexate or leflunomide and 1 TNF blocker (Enbrel or Humira). For PsA: Trial of, medical reason for not using, or contraindication to 1 TNF blocker (Enbrel or Humira). For UC: Trial of, medical reason for not using, or contraindication to 1 of the following conventional therapies: mercaptopurine, an aminosalicylate (i.e. mesalamine, sulfasalazine, azathioprine), or a corticosteroid (i.e. prednisone, methylprednisolone) and 1 TNF blocker (Enbrel or Humira).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	New starts: Serum calcium levels. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of hepatic encephalopathy (HE): trial of, contraindication to, or medical reason for not using lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBSD): 1) trial of, contraindication to, or medical reason for not using loperamide and dicyclomine AND 2) no more than 3 courses of 14 days each. For travelers diarrhea (TD) caused by noninvasive strains of E. Coli (with no bloody stools or fever): patient must be intolerant to or must have had a trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Age Restrictions	N/A
Prescriber Restrictions	For HE: gastroenterologist or hepatologist. For IBS-D: gastroenterologist.
Coverage Duration	For HE: contract year. For IBSD: 14 days (cannot exceed 3 courses of 14 days each). For TD: 3 days.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist, allergist, immunologist, dermatologist, or otolaryngologist.
Coverage Duration	New Starts: 6 months. Cont of therapy or reauth until end of contract year.
Other Criteria	New starts for moderate to severe persistent allergic asthma: 1) Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) Pretreatment serum IgE levels greater than 30 IU/mL, AND 3) Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months, or there is a medical reason for not using these drugs. Continuation of therapy or reauthorization criteria for moderate to severe persistent allergic asthma: 1) Reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, OR 2) Reduction of rescue inhaler use, OR 3) Documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). New starts for chronic idiopathic urticaria: 1) inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated), AND 2) disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria. Continuation of therapy or reauthorization criteria for chronic idiopathic urticaria: 1) improvement from baseline of symptoms associated with urticaria within 6 months of Xolair use. New starts for c: 1) currently using an intranasal corticosteroid, will be prescribed an intranasal corticosteroid with request, or has a medical reason

PA Criteria	Criteria Details
	for not using an intranasal corticosteroid. Continuation of therapy or reauthorization criteria for nasal polyps: 1) Documentation has been provided that demonstrates a clinical benefit (e.g. improvements in symptom severity, nasal polyp score [NPS], sino-nasal outcome test-22 [SNOT-22], nasal congestion score [NCS]) AND 2) continued use of intranasal corticosteroid, or has a medical reason for not using one.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist, pulmonologist, or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For somnolence associated with narcolepsy: trial of, contraindication to, or medical reason for not using an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For cataplexy associated with narcolepsy, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XYWAV

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist or a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.). For the treatment of cataplexy associated with narcolepsy or idiopathic hypersomnia, approve.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG, 405 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The member has taken oral olanzapine without significant side effects. Trial of, contraindication to, or medical reason for not using Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- AMINOSYN II INTRAVENOUS SOLUTION 15 %
- AMINOSYN-PF 7% INTRAVENOUS SOLUTION 7 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 7 %
- *amphotericin b intravenous solution reconstituted 50 mg*
- *amphotericin b liposome intravenous suspension reconstituted 50 mg*
- *aprepitant oral 80 & 125 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dexamethasone sodium phosphate injection solution 120 mg/30ml, 20 mg/5ml, 4 mg/ml*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- GENGRAF ORAL CAPSULE 100 MG, 25 MG

- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl oral tablet 1 mg*
- *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml*
- HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- *nalbuphine hcl injection solution 10 mg/ml*
- NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- *prehevbrio intramuscular suspension 10 mcg/ml*
- PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
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- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml*
- *tobramycin inhalation nebulization solution 300 mg/5ml*
- *ziprasidone mesylate intramuscular solution reconstituted 20 mg*

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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