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

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

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

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

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

Affected Drugs:
Tymlos

Off-Label Uses:N/A

Exclusion Criteria:POSTMENOPAUSAL OSTEOPOROSIS: PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:POSTMENOPAUSAL OSTEOPOROSIS: ONE OF THE FOLLOWING: 1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S), B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. 2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). 3) TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO ONE BISPHOSPHONATE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Orencia
Orencia ClickJect

***Pending CMS Review**

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

Affected Drugs:
Verzenio

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:ADVANCED OR METASTATIC BREAST CANCER: THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Abiraterone Acetate
Abirtega

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Yonsa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Calquence

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Krazati

***Pending CMS Review**

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

Affected Drugs:
Humira (2 Pen)
Humira (2 Syringe)
Humira-CD/UC/HS Starter
Humira-Psoriasis/Uveit Starter

***Pending CMS Review**

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

Affected Drugs:
Gilotrif

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Alecensa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Piqray (200 MG Daily Dose)
Piqray (250 MG Daily Dose)
Piqray (300 MG Daily Dose)
Vijoice

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Amikacin Sulfate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DIAGNOSIS

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:3 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Kineret

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:RHEUMATOID ARTHRITIS (RA) (INITIAL): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

Coverage Duration:12 Months

Other Criteria:RHEUMATOID ARTHRITIS (RA) (INITIAL): ONE OF THE FOLLOWING: A) EITHER A TRIAL AND FAILURE, CONTRAINDICATION, OR INTOLERANCE (TF/C/I) TO TWO OF THE FOLLOWING: ENBREL (ETANERCEPT), HUMIRA (ADALIMUMAB), ORENCIA (ABATACEPT), RINVOQ (UPADACITINIB), XELJANZ/XELJANZ XR (TOFACITINIB), OR ATTESTATION DEMONSTRATING A TRIAL MAY BE INAPPROPRIATE, OR B) FOR CONTINUATION OF PRIOR THERAPY. NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID) (INITIAL): DIAGNOSIS OF NOMID HAS BEEN CONFIRMED BY ONE OF THE FOLLOWING: 1) NLRP-3 (NUCLEOTIDE-BINDING DOMAIN, LEUCINE RICH FAMILY (NLR), PYRIN DOMAIN CONTAINING 3) GENE (ALSO KNOWN AS COLD-INDUCED AUTO-INFLAMMATORY SYNDROME-1 [CIAS1]) MUTATION OR 2) BOTH OF THE FOLLOWING: A) TWO OF THE FOLLOWING CLINICAL SYMPTOMS: URTICARIA-LIKE RASH, COLD/STRESS TRIGGERED EPISODES, SENSORINEURAL HEARING LOSS, MUSCULOSKELETAL SYMPTOMS (E.G., ARTHRALGIA, ARTHRITIS, MYALGIA), CHRONIC ASEPTIC MENINGITIS, OR SKELETAL ABNORMALITIES (E.G., EPIPHYSEAL OVERGROWTH, FRONTAL BOSSING) AND B) ELEVATED ACUTE PHASE REACTANTS (EG, ERYTHROCYTE SEDIMENTATION RATE [ESR], C-REACTIVE PROTEIN [CRP], SERUM AMYLOID A [SAA]). DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA): DIAGNOSIS OF DIRA. RENEWAL: RA, NOMID: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

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

Prerequisite Therapy Required: No

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

Affected Drugs:
Erleada

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): PATIENT HAS HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: DIAGNOSIS OF NMCRPC OR MCSPC.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Apomorphine HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:RENEWAL: PATIENT HAD IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF APOMORPHINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Otezla

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: PLAQUE PSORIASIS (PSO):PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA.

Age Restrictions:N/A

Prescription Order Restrictions:PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION. FOR BEHCET'S DISEASE: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Arikayce

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY, OR IN CONSULTATION WITH, AN INFECTIOUS DISEASE SPECIALIST OR PULMONOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Scemblix

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Qulipta

***Pending CMS Review**

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

Affected Drugs:
Tavneos

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:POSITIVE TEST FOR ANTI-PR3 OR ANTI-MPO (PROTEINASE 3 OR MYELOPEROXIDASE ANTIBODIES) OR POSITIVE TISSUE BIOPSY.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:COVERED FOR PATIENTS WITH CLINICAL DIAGNOSIS OF ANCA VASCULITIS GPA OR MPA, OR ANCA-POSITIVE VASCULITIS IN COMBINATION WITH STANDARD THERAPY, INCLUDING GLUCOCORTICOIDS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ayvakit

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Doptelet

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:CHRONIC LIVER DISEASE (CLD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.

Coverage Duration:CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:CLD: INITIAL: PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC ITP: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: CORTICOSTEROIDS OR IMMUNOGLOBULINS, OR INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: PATIENT HAD A CLINICAL RESPONSE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Avmapki Fakzynja Co-Pack

***Pending CMS Review**

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

Affected Drugs:
Inlyta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Onureg

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cayston

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:AT LEAST 7 YEARS OLD

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Sirturo

***Pending CMS Review**

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

Affected Drugs:
Benlysta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: CLINICAL IMPROVEMENT IN RENAL RESPONSE COMPARED TO BASELINE OR CLINICAL PARAMETERS (E.G., FLUID RETENTION, USE OF RESCUE DRUGS, GLUCOCORTICOID DOSE).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rezurock

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Welireg

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nexletol
Nexlizet

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: A) Treatment of heterozygous familial hypercholesterolemia (HeFH), or B) Treatment of atherosclerotic cardiovascular disease. 2) Document (only for first prescription): A) Patient is using concurrent LDL lowering therapies or prescriber attestation patient is unable to take recommended statin therapy or other LDL lowering therapies, and B) Lipid panel results (baseline LDL-C level must be greater than 70 mg/dL).

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Cardiologist, 2) Endocrinologist, 3) Internist, 4) Lipid Disorders Specialist or 5) Vascular Surgeon

Coverage Duration:12 MONTHS

Other Criteria:1) Atherosclerotic cardiovascular disease (CVD) can be considered as: acute coronary syndromes (ACS), stroke, myocardial infarction, transient ischemic attack, stable or unstable angina, peripheral arterial disease, coronary or arterial revascularization, or myocardial revascularization procedures (CABG or PCI). 2) FDA recommends avoiding concomitant use of simvastatin in doses greater than 20 mg, and pravastatin in doses greater than 40 mg.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Fasenra
Fasenra Pen

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.

Age Restrictions:N/A

Prescription Order Restrictions:ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.

Coverage Duration:12 MONTHS

Other Criteria:ASTHMA: INITIAL: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

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

Prerequisite Therapy Required: No

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

Affected Drugs:
Orladeyo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.

Age Restrictions:N/A

Prescription Order Restrictions:HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE, RENEWAL: IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Bexarotene

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mektovi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Bosulif

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT T315I, V299L, G250E, OR F317L MUTATIONS ARE NOT PRESENT.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Alunbrig

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cinryze

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.

Age Restrictions:N/A

Prescription Order Restrictions:HAE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.

Coverage Duration:12 MONTHS

Other Criteria:HAE: CINRYZE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE. RENEWAL: IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Haegarda

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.

Age Restrictions:N/A

Prescription Order Restrictions:HAE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.

Coverage Duration:12 MONTHS

Other Criteria:HAE: HAEGARDA: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE. RENEWAL: IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cometriq (100 MG Daily Dose)
Cometriq (140 MG Daily Dose)
Cometriq (60 MG Daily Dose)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cabometyx

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Epidiolex

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CLOBAZAM, TOPIRAMATE, LAMOTRIGINE. RENEWAL: DS, LGS, TSC: CONFIRMATION OF DIAGNOSIS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Truqap

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:DIAGNOSIS OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER: A) EVIDENCE OF PIK3CA/AKT1/PTEN MUTATIONS, B) PROGRESSION ON AT LEAST ONE ENDOCRINE-BASED REGIMEN IN THE METASTATIC SETTING OR RECURRENCE ON OR WITHIN 12 MONTHS IF USED AS ADJUVANT THERAPY, AND C) WILL BE USED IN COMBINATION WITH FULVESTRANT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cablivi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tabrecta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zykadia

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mavenclad (10 Tabs)
Mavenclad (4 Tabs)
Mavenclad (5 Tabs)
Mavenclad (6 Tabs)
Mavenclad (7 Tabs)
Mavenclad (8 Tabs)
Mavenclad (9 Tabs)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:48 WEEKS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
cloBAZam

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Sympazan

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:LENNOX-GASTAUT SYNDROME (LGS): 1) PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cotellic

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Acthar
Acthar Gel
Cortrophin
Cortrophin Gel

***Pending CMS Review**

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

Affected Drugs:
Cresemba

Off-Label Uses:N/A

Exclusion Criteria:1) Coadministration with strong CYP3A4 inhibitors, such as ketoconazole or high-dose ritonavir, 2) Coadministration with strong CYP3A4 inducers, such as rifampin, carbamazepine, or long acting barbiturates

Required Medical Information:1) Diagnosis: Invasive aspergillosis or mucormycosis.

Age Restrictions:6 years of age and older weighing at least 16 kg

Prescription Order Restrictions:1) Infectologist

Coverage Duration: Initial: 6 months. Renewal: 12 months.

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xalkori

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cystaran

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tafinlar

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vizimpro

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Dalfampridine ER

***Pending CMS Review**

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

Affected Drugs:
Danziten

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nubeqa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): PATIENT HAS HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: DIAGNOSIS OF NMCRPC OR MHSPC.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Dasatinib

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Inqovi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Deferasirox
Deferasirox Granules

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER. INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO A GENERIC EQUIVALENT OF EITHER EXJADE TABLET FOR ORAL SUSPENSION OR A FORMULARY VERSION OF DEFERASIROX TABLET.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Deferiprone
Ferriprox

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL CRITERIA: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: (1) TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE, AND (2) ONE OF THE FOLLOWING CRITERIA: A) PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS OR HAS A CONTRAINDICATION TO THESE THERAPIES, OR B) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: I) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), OR II) EVIDENCE OF CARDIAC IRON ACCUMULATION (I.E., CARDIAC T2 STAR MRI LESS THAN 10 MILLISECONDS, IRON INDUCED CARDIOMYOPATHY, FALL IN LEFT VENTRICULAR EJECTION FRACTION, ARRHYTHMIA INDICATING INADEQUATE CHELATION). TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Deflazacort

***Pending CMS Review**

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

Affected Drugs:
Firmagon
Firmagon (240 MG Dose)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Baxdela

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:ONE MONTH

Other Criteria:ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE STANDARD OF CARE AGENT FOR ABSSSI (E.G., SULFAMETHOXAZOLE/TRIMETHOPRIM, LEVOFLOXACIN, CLINDAMYCIN, CEPHALEXIN, OR VANCOMYCIN), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS FOR ABSSSI: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC. COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xgeva

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Austedo
Austedo XR
Austedo XR Patient Titration

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.

Coverage Duration:12 MONTHS

Other Criteria:TARDIVE DYSKINESIA: PATIENT HAS A HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Keveyis

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS AND OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: PATIENT DOES NOT HAVE HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN. RENEWAL: IMPROVEMENT IN SYMPTOMS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Diclofenac Epolamine

***Pending CMS Review**

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

Affected Drugs:
Diclofenac Sodium

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:DICLOFENAC 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Dimethyl Fumarate
Dimethyl Fumarate Starter Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vumerity

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
droNABinol

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:6 MONTHS

Other Criteria:B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Droxidopa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.

Coverage Duration:INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

Other Criteria:INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Dupixent

***Pending CMS Review**

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

Affected Drugs:
Copiktra

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Iwilfin

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Orserdu

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Orilissa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE AND OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION. RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Trikafta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: LIFETIME.

Other Criteria:RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cerdelga

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Promacta

***Pending CMS Review**

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

Affected Drugs:
IDHIFA

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Braftovi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ambrisentan
Opsumit
Tracleer

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS

Other Criteria:INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER. AMBRISENTAN: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). FORMULARY VERSION OF BOSENTAN: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rozlytrek

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xtandi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:INITIAL: 1.) DIAGNOSIS: A) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC), B) NON-METASTATIC CASTRATION RESISTANT PROSTATE CANCER (nmCRPC), C) METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (mCSPC), OR D) NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (nmCSPC) WITH BIOCHEMICAL RECURRENCE AT HIGH RISK FOR METASTASIS. 2) FOR MCRPC, NMCRPC AND MCSPC DOCUMENT: PATIENT IS RECEIVING A GONADOTROPIN-RELEASING HORMONE (GNRH) ANALOG CONCURRENTLY (E.G., LEUPROLIDE, GOSERELIN, TRIPTORELIN, OR HISTRELIN), HAD A BILATERAL ORCHIECTOMY, OR CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL). 3) PATIENTS WITH NMCSPC WITH BIOCHEMICAL RECURRENCE AT HIGH RISK FOR METASTASIS MAY BE TREATED WITH OR WITHOUT A GNRH ANALOG. RENEWAL: DIAGNOSIS: A) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC), B) NON-METASTATIC CASTRATION RESISTANT PROSTATE CANCER (nmCRPC), C) METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (mCSPC), OR D) NON-METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (nmCSPC) WITH BIOCHEMICAL RECURRENCE AT HIGH RISK FOR METASTASIS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Balversa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Aimovig

***Pending CMS Review**

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

Affected Drugs:
Erlotinib HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Retacrit

***Pending CMS Review**

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

Affected Drugs:
Enbrel
Enbrel Mini
Enbrel SureClick

***Pending CMS Review**

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

Affected Drugs:
Everolimus

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF SUNITINIB OR SORAFENIB.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vowst

***Pending CMS Review**

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

Affected Drugs:
Inrebic

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:INITIAL: MYELOFIBROSIS: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF JAKAFI (RUXOLITINIB). RENEWAL: MYELOFIBROSIS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Fintepla

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Veozah

Off-Label Uses:N/A

Exclusion Criteria:A) KNOWN CIRRHOSIS, B) SEVERE RENAL IMPAIRMENT OR END-STAGE RENAL DISEASE, C) CONCOMITANT USE WITH CYP1A2 INHIBITORS

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:DIAGNOSIS OF MODERATE TO SEVERE VASOMOTOR SYMPTOMS DUE TO MENOPAUSE: A) DOCUMENTATION OF CONTRAINDICATION, INTOLERANCE, OR INADEQUATE RESPONSE TO GREATER THAN OR EQUAL TO 1 MENOPAUSAL HORMONAL TREATMENTS (I.E PREMARIN, ESTRADIOL, DUAVEE).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nivestym
Zarxio

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:NIVESTYM IS THE PREFERRED FILGRASTIM PRODUCT. REQUESTS FOR NIVESTYM DOES NOT REQUIRE A STEP. OTHER FORMULARY VERSIONS OF FILGRASTIM PRODUCTS WILL REQUIRE A TRIAL OF OR CONTRAINDICATION TO NIVESTYM, WHERE INDICATIONS ALIGN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Kerendia

***Pending CMS Review**

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

Affected Drugs:
Fingolimod HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Eulexin

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tavalisse

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.

Coverage Duration:INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Fruzaqla

***Pending CMS Review**

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

Affected Drugs:
Lytgobi (12 MG Daily Dose)
Lytgobi (16 MG Daily Dose)
Lytgobi (20 MG Daily Dose)

***Pending CMS Review**

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

Affected Drugs:
Emgality
Emgality (300 MG Dose)

***Pending CMS Review**

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

Affected Drugs:
Ztalmy

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DIAGNOSIS: TREATMENT OF SEIZURES ASSOCIATED WITH CYCLIN-DEPENDENT KINASE-LIKE 5 (CDKL5) DEFICIENCY DISORDER (CDD). DOCUMENTATION SHOWING GENETIC TESTING CONFIRMING CDLK5 DEFICIENCY

Age Restrictions:2 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULATION BY A NEUROLOGIST, OR GENETICIST

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Gefitinib

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xospata

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Daurismo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Glatiramer Acetate
Glatopa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mavyret

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:HCV RNA LEVEL.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

Coverage Duration:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Other Criteria:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mounjaro
Ozempic (0.25 or 0.5 MG/DOSE)
Ozempic (1 MG/DOSE)
Ozempic (2 MG/DOSE)
Rybelsus
Trulicity

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 months

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ravicti

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: UREA CYCLE DISORDER (UCD): DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:INITIAL: UREA CYCLE DISORDER (UCD): TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL). RENEWAL: UCD: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tremfya
Tremfya Pen
Tremfya-CD/UC Induction

***Pending CMS Review**

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

Affected Drugs:
Hernexeos

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Unresectable or metastatic non-squamous non-small cell lung cancer (NSCLC). 2) Document: i) HER2 [ERBB2] tyrosine kinase domain activating mutations, as detected by an FDA-approved test, AND ii) Patient has received prior systemic therapy, including platinum-based chemotherapy (e.g., cisplatin, carboplatin, oxaliplatin, etc.).

Age Restrictions:18 years of age or older

Prescription Order Restrictions: Hematologist/Oncologist

Coverage Duration: End of Contract Year

Other Criteria:FDA-approved test (to validate HER2 [ERBB2] tyrosine kinase domain activating mutations): Oncomine Dx Target Test (Life Technologies Corporation, Tissue-test).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Morphine Sulfate (Concentrate)

***Pending CMS Review**

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

Affected Drugs:
Cyclobenzaprine HCl
Cyproheptadine HCl
Dicyclomine HCl
Diphenoxylate-Atropine
Disopyramide Phosphate
hydrOXYzine HCl
Promethazine HCl
Scopolamine
Trihexyphenidyl HCl

***Pending CMS Review**

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

Affected Drugs:
PARoxetine HCl

***Pending CMS Review**

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

Affected Drugs:
Imbruvica

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ibtrozi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Patient has locally advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) 2) Document: Patient has documented ROS1 + NSCLC 3) Ibtrozi is given as monotherapy

Age Restrictions:18 years of age or older

Prescription Order Restrictions: Hematologist/Oncologist

Coverage Duration: End of Contract Year

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Icatibant Acetate
Sajazir

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zydelig

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Imatinib Mesylate
Imkeldi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.

Other Criteria:PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Itovebi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Actimmune

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:RENEWAL: THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE AND HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Avonex Pen
Avonex Prefilled
Betaseron
Plegridy

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Kalydeco

Off-Label Uses:N/A

Exclusion Criteria:HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.

Required Medical Information:CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT

Coverage Duration:INITIAL: 12 MONTHS. RENEWAL: LIFETIME

Other Criteria:RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tibsovo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ninlaro

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Takhzyro

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.

Age Restrictions:N/A

Prescription Order Restrictions:HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE, RENEWAL: IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lapatinib Ditosylate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vitrakvi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:APPROVAL FOR VITRAKVI ORAL SOLUTION: TRIAL OF VITRAKVI CAPSULES OR PATIENT IS UNABLE TO TAKE CAPSULE FORMULATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lazcluze

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLSC), 2) DOCUMENT: CONFIRMATION OF EGFR EXON 19 DELETIONS OR EXON 21 L858R SUBSTITUTION MUTATION, 3) PATIENT MUST BE RECEIVING ANTICOAGULANT VTE PROPHYLAXIS FOR THE FIRST 4 MONTHS OF TREATMENT AND 4) PATIENT WILL BE USING LAZCLUZE (LAZERTINIB) IN COMBINATION WITH AMIVANTAMAB.

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:1) VALIDATE THAT THE TREATMENT REGIMEN IS FOLLOWING THE MOST UP TO DATE NCCN GUIDELINES RECOMMENDATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ledipasvir-Sofosbuvir

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:HCV RNA LEVEL WITHIN PAST 6 MONTHS.

Age Restrictions:N/A

Prescription Order Restrictions:GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

Coverage Duration:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Other Criteria:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/RITONAVIR.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lenalidomide

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
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)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Prevymis

***Pending CMS Review**

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

Affected Drugs:
Inbrija

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:PD: INITIAL: 1) PATIENT IS NOT CURRENTLY TAKING MORE THAN 1600MG OF LEVODOPA PER DAY. RENEWAL: PATIENT HAD IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF INBRIJA.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Endari
L-Glutamine

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:SICKLE CELL DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST.

Coverage Duration:INITIAL: 12 MONTHS. RENEWAL: LIFETIME.

Other Criteria:INITIAL: PATIENTS 18 YEARS OR OLDER: ONE OF THE FOLLOWING: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, OR 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. PATIENTS 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lidocaine
Lidocaine HCl
Tridacaine II
ZTlido

***Pending CMS Review**

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

Affected Drugs:
Lidocaine-Prilocaine

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

PA Indications: All Medically-accepted Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Juxtapid

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:1) DIAGNOSIS DETERMINED BY A) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, OR B) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR C) CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. 2) LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. 3) TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. 4) MEETS ONE OF THE FOLLOWING: A) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, B) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, C) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), D) STATIN INTOLERANCE, OR E) TRIAL OF ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Gleostine

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 months

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lorbrena

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xdemvy

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH OPHTHALMOLOGIST OR OPTOMETRIST

Coverage Duration:6 WEEKS

Other Criteria:DIAGNOSIS OF DEMODEX BLEPHARITIS: A) PRESENCE OF ERYTHEMA IN THE UPPER EYELID MARGIN AND B) PRESENCE OF MITES IN EYELASHES.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Orkambi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.

Age Restrictions:N/A

Prescription Order Restrictions:CF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.

Coverage Duration:CF: INITIAL: 6 MONTHS, RENEWAL: LIFETIME.

Other Criteria:RENEWAL: CF: PATIENT MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mulpleta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON.

Coverage Duration:1 MONTH

Other Criteria:1) PATIENT HAS A PLANNED PROCEDURE 8 TO 14 DAYS AFTER INITIATION OF MULPLETA AND 2) PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., AVATROMBOPAG, ROMIPLOSTIM, ELTROMBOPAG).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Livtencity

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, ONCOLOGIST, INFECTIOUS DISEASE, OR TRANSPLANT SPECIALIST.

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nucala

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.

Age Restrictions:N/A

Prescription Order Restrictions:ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.

Coverage Duration:INITIAL:CRSWNP: 6 MO. OTHER INDICATIONS: 12 MO. RENEWAL:CRSWNP, ASTHMA: 12 MO.

Other Criteria:INITIAL: ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. CRSWNP: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, AND 3) PRESCRIBED AS AN ADD-ON THERAPY TO CURRENT THERAPY. RENEWAL: ASTHMA: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR

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

FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. CRSWNP: IMPROVEMENT WHILE ON THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rydapt

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
miFEPRIStone

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: CUSHINGS SYNDROME (CS): DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).

Age Restrictions:N/A

Prescription Order Restrictions:CS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:CD: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS, RENEWAL: 1) PATIENT CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) PATIENT CONTINUES TO HAVE TOLERABILITY TO MIFEPRISTONE, AND 3) PATIENT CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Galafold

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: FABRY DISEASE: PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.

Age Restrictions:N/A

Prescription Order Restrictions:FABRY DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.

Coverage Duration:INITIAL: 6 MOS. RENEWAL: 12 MOS.

Other Criteria:FABRY DISEASE: INITIAL: NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME), RENEWAL: PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
migLUstat

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Impavido

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Gomekli

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Treatment of Neurofibromatosis Type 1 (NF1), 2) Document: a) Patient has symptomatic and inoperable plexiform neurofibromas (PN), and b) Patients body surface area (BSA) or actual body weight and height.

Age Restrictions:2 years of age or older

Prescription Order Restrictions:1) Geneticist, 2) Neurologist, 3) Neurosurgeon, 4) Hematologist/Oncologist, 5) Ophthalmologist, or 6) Orthopedic Surgeon

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Pyrukynd
Pyrukynd Taper Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DIAGNOSIS: TREATMENT OF HEMOLYTIC ANEMIA IN ADULTS WITH PYRUVATE KINASE (PK) DEFICIENCY. FOR INITIAL EVALUATION DOCUMENT: MUTATION IN THE PKLR GENE (MUST HAVE AT LEAST 2 MUTANT ALLELES IN THE PKLR GENE, OF WHICH AT LEAST 1 WAS A MISSENSE MUTATION). CURRENT HEMOGLOBIN LEVEL (MUST BE LESS THAN OR EQUAL TO 10 MG/DL). FOR RENEWALS DOCUMENT: PATIENT HAS EXPERIENCED IMPROVEMENT FROM BASELINE OR REDUCTION IN TRANSFUSION BURDEN.

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Modeyso

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: a) Diffuse midline glioma (DMG). 2) Document: a) Confirmed diagnosis of DMG with documentation of H3 K27M mutation, b) Disease progression after radiotherapy AND c) For pediatric patients only: Actual body weight (weight-based dosing).

Age Restrictions:1 year of age and older

Prescription Order Restrictions: Hematologist/Oncologist

Coverage Duration: End of Contract Year

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ojjaara

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nerlynx

***Pending CMS Review**

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

Affected Drugs:
Nilotinib HCl
Tasigna

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, F359V/C/I, OR G250E.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ofev

Off-Label Uses:N/A

Exclusion Criteria:INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER). SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF ILD [E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY (CYCLOPHOSPHAMIDE, METHOTREXATE, ACE-INHIBITORS), RECURRENT ASPIRATION (SUCH AS FROM GERD), PULMONARY VASCULAR DISEASE, PULMONARY EDEMA, PNEUMONIA, CHRONIC PULMONARY THROMBOEMBOLISM, ALVEOLAR HEMORRHAGE OR ILD CAUSED BY ANOTHER RHEUMATIC DISEASE, SUCH AS MIXED CONNECTIVE TISSUE DISEASE (MCTD)].

Required Medical Information:INITIAL: IPF: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SSC-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. PF-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.

Age Restrictions:INITIAL: IPF, SSC-ILD, PF-ILD: 18 YEARS OR OLDER.

Prescription Order Restrictions:IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.

Coverage Duration:INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL: 12 MOS.

Other Criteria:INITIAL: IPF: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET. SSC-ILD: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED

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

IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zejula

***Pending CMS Review**

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

Affected Drugs:
Akeega

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ogsiveo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:DIAGNOSIS TREATMENT OF PROGRESSING DESMOID TUMORS (DTS): TUMOR PROGRESSION (E.G. A) IMAGING SCANS SUCH AS CT, MRI, OR ULTRASOUND, B) AT LEAST ONE LINE OF THERAPY SUCH AS SURGERY, RADIOTHERAPY, OR SYSTEMIC THERAPY OR C) PRESCRIBER DOCUMENTATION THAT STATES DISEASE PROGRESSION).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nitisinone
Nityr
Orfadin

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: HEREDITARY TYROSINEMIA TYPE 1 (HT-1): DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.

Age Restrictions:N/A

Prescription Order Restrictions:HT-1: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.

Coverage Duration:INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

Other Criteria:HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED FORMULARY NITISINONE TABLETS OR CAPSULES, RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ocaliva

Off-Label Uses:N/A

Exclusion Criteria:PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.

Required Medical Information:INITIAL: DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS (PBC) AS CONFIRMED BY TWO OF THE FOLLOWING: 1) ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), 2) PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, OR 3) HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.

Age Restrictions:N/A

Prescription Order Restrictions:PBC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:PBC: INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID, RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Kesimpta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lybalvi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:SCHIZOPHRENIA/BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST

Coverage Duration:12 MONTHS

Other Criteria:SCHIZOPHRENIA: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO LATUDA OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lynparza

***Pending CMS Review**

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

Affected Drugs:
Rezlidhia

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:RELAPSED OR REFRACTORY ACUTE MYELOID LEUKEMIA (AML) WITH A SUSCEPTIBLE IDH1 MUTATION: 1.) DOCUMENTATION OF PRESENCE OF SUSCEPTIBLE IDH1 MUTATION AS DETERMINED BY AN FDA APPROVED TEST.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xolair

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.

Age Restrictions:N/A

Prescription Order Restrictions:INITIAL AND RENEWAL: CHRONIC SPONTANEOUS URTICARIA (CSU): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.

Coverage Duration:INITIAL:ASTHMA: 12 MO. CSU, CRSWNP, IGE-FA: 6 MO. RENEWAL:ASTHMA, CRSWNP, IGE-FA: 12 MO. CSU: 6 MO.

Other Criteria:INITIAL:CSU: TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. CRSWNP:1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, AND 3) PRESCRIBED AS AN ADD-ON THERAPY TO CURRENT THERAPY. ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) XOLAIR WILL BE

USED AS ADD-ON MAINTENANCE TREATMENT, AND 4) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: CSU AND CRSWNP: IMPROVEMENT WHILE ON THERAPY. ASTHMA: CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tagrisso

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:METASTATIC NSCLC WITH EGFR T790M MUTATION: PATIENT IS NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vonjo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information: Initial: 1) Diagnosis of intermediate- or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis in patients, AND 2) Documentation of platelet count below 50 x 10^9/L

Age Restrictions:N/A

Prescription Order Restrictions: Prescribed by or in consultation with a hematologist or oncologist

Coverage Duration: Initial: 4 months Renewal: 12 months

Other Criteria: Myelofibrosis: Renewal: Continues to benefit from the medication

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ibrance

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Signifor

***Pending CMS Review**

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

Affected Drugs:
PAZOPanib HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Praluent
Repatha
Repatha Pushtronex System
Repatha SureClick

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 months

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Alyq
Sildenafil Citrate
Tadalafil (PAH)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

Age Restrictions:N/A

Prescription Order Restrictions:PAH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS

Other Criteria:PAH: INITIAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, RENEWAL: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Fulphila
Neulasta
Nyvepria
Udenyca

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:NYVEPRIA IS THE PREFERRED PEGFILGRASTIM PRODUCT. REQUESTS FOR NYVEPRIA DOES NOT REQUIRE A STEP. OTHER FORMULARY VERSIONS OF PEGFILGRASTIM PRODUCTS WILL REQUIRE A TRIAL OF OR CONTRAINDICATION TO NYVEPRIA, WHERE INDICATIONS ALIGN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Palynziq

***Pending CMS Review**

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

Affected Drugs:
Somavert

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Pemazyre

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
penicillAMINE
Tiopronin

Off-Label Uses:N/A

Exclusion Criteria:INITIAL AND RENEWAL: FORMULARY VERSION OF PENICILLAMINE: RHEUMATOID ARTHRITIS (RA): HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY.

Required Medical Information:INITIAL: WILSONS DISEASE: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, 2) IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. RENEWAL: WILSONS DISEASE, CYSTINURIA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

Age Restrictions:N/A

Prescription Order Restrictions:WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

Coverage Duration:INITIAL: 12 MONTHS, RENEWAL: LIFETIME.

Other Criteria:INITIAL: RA, WILSONS DISEASE: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) AND A FORMULARY VERSION OF TIOPRONIN (THIOLA)/THIOLA EC. RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE

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

IS REQUIRED. RENEWAL: RA: EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Turalio

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nuplazid

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:18 YEARS OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).

Coverage Duration:INITIAL 12 MONTHS. RENEWAL 12 MONTHS.

Other Criteria:RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Pirfenidone

Off-Label Uses:N/A

Exclusion Criteria:INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, OR CANCER).

Required Medical Information:INITIAL: IPF: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE.

Age Restrictions:IPF: 18 YEARS OR OLDER.

Prescription Order Restrictions:IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

Coverage Duration:IPF: INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:RENEWAL: IPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Jaypirca

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Pomalyst

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Iclusig

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Noxafil
Posaconazole

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:OROPHARYNGEAL CANDIDIASIS (OPC): 3 MONTHS. PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.

Other Criteria:POSACONAZOLE SUSPENSION ONLY: 1) OPC: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE OR ITRACONAZOLE. 2) PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. POSACONZOLE TABLETS ONLY: NO EXTRA CRITERIA REQUIRED, ALL FDA APPROVED INDICATION COVERED. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Gavreto

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
SymlinPen 120
SymlinPen 60

***Pending CMS Review**

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

Affected Drugs:
Pyrimethamine

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:TOXOPLASMOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.

Coverage Duration:TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS.

Other Criteria:RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
quiNINE Sulfate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vanflyta

Off-Label Uses:N/A

Exclusion Criteria:CONTRAINDICATED IN PATIENTS WITH SEVERE HYPOKALEMIA, SEVERE HYPOMAGNESEMIA, LONG QT SYNDROME, OR IN PATIENTS WITH A HISTORY OF VENTRICULAR ARRHYTHMIAS OR TORSADES DE POINTES.

Required Medical Information:DIAGNOSIS: FOR THE TREATMENT OF ADULT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 INTERNAL TANDEM DUPLICATION (ITD)-POSITIVE: A) PRESCRIBED IN COMBINATION WITH STANDARD CYTARABINE AND ANTHRACYCLINE (I.E., DAUNORUBICIN) INDUCTION AND CYTARABINE CONSOLIDATION, AND AS MAINTENANCE MONOTHERAPY FOLLOWING CONSOLIDATION CHEMOTHERAPY, B) EVIDENCE OF POSITIVE FLT3 INTERNAL TANDEM DUPLICATION

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:LEUKOSTRAT CDX FLT3 MUTATION ASSAY IS THE FDA-APPROVED TEST FOR SELECTION OF PATIENTS WITH AML FOR VANFLYTA TREATMENT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Stivarga

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Orgovyx

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Augtyro

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:12 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC ROS1-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC): DOCUMENTATION OF ROS1-MUTATED NSCLC. DIAGNOSIS OF SOLID TUMORS THAT NEUROTROPHIC TYROSINE RECEPTOR KINASE (NTRK) GENE FUSION, ARE LOCALLY ADVANCED OR METASTATIC OR WHERE SURGICAL RESECTION IS LIKELY TO RESULT IN SEVERE MORBIDITY, AND HAVE PROGRESSED FOLLOWING TREATMENT OR HAVE NO SATISFACTORY ALTERNATIVE THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Revcovi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients.

Age Restrictions:N/a

Prescription Order Restrictions:1) Geneticist, or 2) Physician specialized in metabolic or genetic disorders

Coverage Duration: Initial: 6 months. Renewal: 12 months.

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Revuforj

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Relapsed or refractory acute leukemia with a lysine methyltransferase 2A gene (KMT2A) translocation in adult and pediatric patients 1 year and older. 2) Document: a) Lysine methyltransferase 2A gene (KMT2A) translocation

Age Restrictions:1 year of age or older

Prescription Order Restrictions: Hematologist/Oncologist

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rezdiffra

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis:Â noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis). 2) Document: A) F2/F3 fibrosis confirmed by biopsy or non-invasive tests (NITâ€™s), B) Prescriber attestation that patient has received counseling on diet, exercise and alcohol consumption.

Age Restrictions:18 years of age and older

Prescription Order Restrictions:1) Hepatologist, 2) Gastroenterologist

Coverage Duration:12 months

Other Criteria:F2/F3 fibrosis must be confirmed by biopsy or non-invasive tests (NITs) (There is no generally accepted NIT or combination of NITs that is used to diagnose NASH. FibroScan or MRE + MRI-PDFF are reasonable methods.)

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Kisqali (200 MG Dose)
Kisqali (400 MG Dose)
Kisqali (600 MG Dose)
Kisqali Femara (400 MG Dose)
Kisqali Femara (600 MG Dose)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:REQUIRES A TRIAL OF OR CONTRAINDICATION TO VERZENIO OR IBRANCE WHERE INDICATIONS ALIGN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xifaxan

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:TRAVELERS DIARRHEA/HE: 12 MOS. IBS-D: 12 WKS.

Other Criteria:RIFAXIMIN 550 MG TABLETS: HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Nurtec

***Pending CMS Review**

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

Affected Drugs:
Adempas

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

Age Restrictions:N/A

Prescription Order Restrictions:PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: PAH: NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS, OR ANY PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Qinlock

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Skyrizi
Skyrizi Pen

***Pending CMS Review**

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

Affected Drugs:
Evrysdi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:SMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST

Coverage Duration:SMA: INITIAL/RENEWAL: 12 MONTHS

Other Criteria:SPINAL MUSCULAR ATROPHY (SMA): INITIAL: DOCUMENTATION OF GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: DOCUMENTATION OF UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING. FOR SYMPTOMATIC PATIENTS: 1) ONSET OF SMA SYMPTOMS OCCURRED BEFORE 20 YEARS OF AGE, 2) DOCUMENTATION OF BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, 3) IF PREVIOUSLY RECEIVED GENE THERAPY, THE PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR OTHER MUSCLE FUNCTION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Evenity

***Pending CMS Review**

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

Affected Drugs:
Besremi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rubraca

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Jakafi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:MYELOFIBROSIS RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD): NO RENEWAL CRITERIA.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Cosentyx
Cosentyx (300 MG Dose)
Cosentyx Sensoready (300 MG)
Cosentyx UnoReady

***Pending CMS Review**

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

Affected Drugs:
Uptravi
Uptravi Titration

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS.

Age Restrictions:N/A

Prescription Order Restrictions:PAH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS

Other Criteria:INITIAL: PAH: WHO FC II-III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAN RECEPTOR ANTAGONIST (E.G., AMBRISENTAN, BOSENTAN, MACITENTAN), 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR (E.G., SILDENAFIL, TADALAFIL), OR 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR (E.G., RIOCIGUAT). WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: NO STEP. RENEWAL: PAH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
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)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Retevmo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Koselugo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Mayzent
Mayzent Starter Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:MULTIPLE SCLEROSIS: RENEWAL: 1) DEMONSTRATION OF CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE AND 2) DOES NOT HAVE LYMPHOPENIA.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xyrem

***Pending CMS Review**

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

Affected Drugs:
Sofosbuvir-Velpatasvir

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:HCV RNA LEVEL.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

Coverage Duration:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

Other Criteria:CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Sunosi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. OBSTRUCTIVE SLEEP APNEA (OSA): THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL. RENEWAL: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Norditropin FlexPro

Off-Label Uses:N/A

Exclusion Criteria:ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.

Required Medical Information:INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.

Age Restrictions:N/A

Prescription Order Restrictions:INITIAL AND RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES. RENEWAL: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES. PWS: IMPROVEMENT IN BODY COMPOSITION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Serostim

***Pending CMS Review**

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

Affected Drugs:
Odomzo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
SORAfenib Tosylate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lumakras

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Diacomit

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:DRAVET SYNDROME: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS.

Other Criteria:RENEWAL: DRAVET SYNDROME: CURRENTLY TREATED WITH CLOBAZAM.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
SUNItinib Malate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Astagraf XL
Envarsus XR

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tadalafil

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:BENIGN PROSTATIC HYPERPLASIA (BPH): DIAGNOSIS OF BPH.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vyndamax
Vyndaqel

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.

Coverage Duration:INITIAL AND RENEWAL: 12 MONTHS

Other Criteria:INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Talzenna

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. ONLY VERIFICATION OF INDICATION FOR PROSTATE CANCER IS NEEDED. THERE ARE NO EXTRA REQUIREMENTS FOR THIS INDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Hetlioz LQ
Tasimelteon

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:LIFETIME

Other Criteria:NON-24 HOUR SLEEP-WAKE DISORDER: PATIENT IS LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tazverik

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Gattex

***Pending CMS Review**

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

Affected Drugs:
Xermelo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tepmetko

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Teriflunomide

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Egrifta SV

***Pending CMS Review**

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

Affected Drugs:
Testosterone
Testosterone Cypionate
Testosterone Enanthate
Xyosted

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: MALE HYPOGONADISM: CONFIRMED BY: 1) AT LEAST TWO MORNING TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS WHILE IN A FASTED STATE, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:PRIMARY OR SECONDARY HYPOGONADISM: 12 MO. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.

Other Criteria:MALE HYPOGONADISM: RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tetrabenazine

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Symdeko

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: LIFETIME

Other Criteria:RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Thalomid

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Fotivda

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Xeljanz
Xeljanz XR

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS. PSA, PCJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS. UC: INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS. RENEWAL: RA, PSA, AS, PCJIA, UC: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Jynarque
Tolvaptan

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Altreno
Tretinoin

Off-Label Uses:N/A

Exclusion Criteria:COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY GENERIC TOPICAL TRETINOIN PRODUCT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Ojemda

***Pending CMS Review**

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

Affected Drugs:
Mekinist

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Trientine HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:WILSONS DISEASE: INITIAL: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS, RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

Age Restrictions:N/A

Prescription Order Restrictions:WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.

Coverage Duration:WILSONS DISEASE: INITIAL: 12 MONTHS, RENEWAL: LIFETIME.

Other Criteria:INITIAL: WILSONS DISEASE: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE (DEPEN).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Lonsurf

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tukysa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Tyenne

***Pending CMS Review**

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

Affected Drugs:
Ubrelvy

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTAN. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT AS DEFINED BY ONE OF THE FOLLOWING: 1) ABILITY TO FUNCTION NORMALLY WITHIN 2 HOURS OF DOSE, 2) HEADACHE PAIN DISAPPEARS WITHIN 2 HOURS OF DOSE, 3) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Rinvoq
Rinvoq LQ

***Pending CMS Review**

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

Affected Drugs:
Stelara
Ustekinumab
Yesintek

***Pending CMS Review**

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

Affected Drugs:
Ingrezza

***Pending CMS Review**

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

Affected Drugs:
Caprelsa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zelboraf

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Venclexta
Venclexta Starting Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Verquvo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:CHRONIC HEART FAILURE (CHF): PATIENT HAS AN EJECTION FRACTION LESS THAN 45 PERCENT. PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS II, III, OR IV SYMPTOMS.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 Months

Other Criteria:CHF: ONE OF THE FOLLOWING: A) PATIENT WAS HOSPITALIZED FOR HEART FAILURE WITHIN THE LAST 6 MONTHS, OR B) PATIENT USED OUTPATIENT INTRAVENOUS DIURETICS (E.G., BUMETANIDE, FUROSEMIDE) FOR HEART FAILURE WITHIN THE LAST 3 MONTHS. CHF: TRIAL AND FAILURE, CONTRAINDICATION, OR INTOLERANCE TO TWO OF THE FOLLOWING AT A MAXIMALLY TOLERATED DOSE: A) ONE OF THE FOLLOWING: 1) ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR (E.G., CAPTOPRIL, ENALAPRIL), 2) ANGIOTENSIN II RECEPTOR BLOCKER (ARB) (E.G., CANDESARTAN, VALSARTAN), OR 3) ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR (ARNI) [E.G., ENTRESTO (SACUBITRIL AND VALSARTAN)], B) ONE OF THE FOLLOWING: 1) BISOPROLOL, 2) CARVEDILOL, OR 3) METOPROLOL SUCCINATE EXTENDED RELEASE, C) SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITOR [E.G., JARDIANCE (EMPAGLIFLOZIN), FARXIGA (DAPAGLIFLOZIN), XIGDUO XR (DAPAGLIFLOZIN AND METFORMIN)], OR D) MINERALOCORTICOID RECEPTOR ANTAGONIST (MRA) [E.G., EPLERENONE, SPIRONOLACTONE].

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Vigabatrin
Vigadrone
Vigafyde
Vigpoder

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:CPS: PATIENT HAS RESPONDED INADEQUATELY TO AT LEAST 2 ANTIEPILEPTIC AGENTS. CPS AND INFANTILE SPASMS: BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Romvimza

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: A) SYMPTOMATIC TENOSYNOVIAL GIANT CELL TUMOR (TGCT)

Age Restrictions:18 years of age and older

Prescription Order Restrictions: Hematologist/Oncologist

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Erivedge

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Voranigo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:12 YEARS OF AGE AND OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.

Coverage Duration:12 MONTHS

Other Criteria:1) DIAGNOSIS: GRADE 2 ASTROCYTOMA OR OLIGODENDROGLIOMA, 2)DOCUMENT: A) SUSCEPTIBLE IDH1 OR IDH2 MUTATION FOLLOWING SURGERY INCLUDING BIOPSY, SUB-TOTAL RESECTION, OR GROSS TOTAL RESECTION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Voriconazole

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:CANDIDA INFECTIONS: 3 MOS. ALL OTHER INDICATIONS: 6 MOS.

Other Criteria:CANDIDA INFECTIONS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE. ALL INDICATIONS: INABILITY TO SWALLOW TABLETS OR AN INDICATION FOR ESOPHAGEAL CANDIDIASIS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Winrevair

***Pending CMS Review**

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

Affected Drugs:
Cobenfy
Cobenfy Starter Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:MUST BE AGE 18 OR OLDER

Prescription Order Restrictions:MUST BE PRESCRIBED BY, OR IN CONSULTATION WITH, A SPECIALIST FOR THE CONDITION BEING TREATED

Coverage Duration:12 MONTHS

Other Criteria:TRIAL AND FAILURE (DEFINED AS AN INADEQUATE RESPONSE) OF TWO OF THE FOLLOWING: ARIPIPRAZOLE, ASENAPINE (SAPHRIS), BREXPIPRAZOLE (REXULTI), CARIPRAZINE (VRAYLAR), CHLOPROMAZINE, HALDOL, HALOPERIDOL, ILOPERIDONE (FANAPT), LUMATEPERONEE (CAPLYTA), LURASIDONE (LATUDA), OLANZAPINE, PALIPERIDONE (INVEGA), PERPHENAZINE, QUETIAPINE, RISPERIDONE, THIORIDAZINE, THIOTHIXENE, TRIFLUOPERAZINE, OR ZIPRASIDONE (AT LEAST A 30-DAY SUPPLY IN THE PRIOR 180 DAYS).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Brukinsa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zelsuvmi

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Molluscum Contagiosum, 2) Document one of the following: a) Member has a chronic skin condition (e.g. eczema, atopic dermatitis,psoriasis), b) secondary bacterial skin infections from the lesions, c) lesions in the genital area, d) a weakened immune system (e.g. HIV/AIDS, patients who are taking immunosuppressive drugs, cancer, transplantation, underdeveloped immunocompetency, etc.), OR e) there is concern for contagion (e.g. other siblings, daycare).

Age Restrictions:1 year of age and older

Prescription Order Restrictions:N/A

Coverage Duration:12 weeks

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Affected Drugs:
Zurzuvae

***Pending CMS Review**

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

Drugs that may be covered under Medicare Part B or Part D

Abelcet IV	Acetylcysteine INH
Acyclovir Sodium IV	Albuterol Sulfate INH
AmBisome IV	Amphotericin B IV
Amphotericin B Liposome IV	Aprepitant Oral Cap
azaTHIOprine Oral Tab	Budesonide INH
Clinimix E/Dextrose (2.75/5) IV	Clinimix E/Dextrose (4.25/10) IV
Clinimix E/Dextrose (4.25/5) IV	Clinimix E/Dextrose (5/15) IV
Clinimix E/Dextrose (5/20) IV	Clinimix/Dextrose (4.25/10) IV
Clinimix/Dextrose (4.25/5) IV	Clinimix/Dextrose (5/15) IV
Clinimix/Dextrose (5/20) IV	Colistimethate Sodium (CBA) INJ
Cromolyn Sodium INH	cycloPHOSphamide Oral Cap
cycloSPORINE Oral Cap	cycloSPORINE Modified Oral Cap
Dextrose IV	Emend Oral Susp
Engerix-B INJ	Everolimus Oral Tab
Fluconazole in Sodium Chloride IV	Gammagard INJ
Gammagard S/D Less IgA IV	Gammaplex IV
Gengraf Oral Cap	Granisetron HCl Oral Tab
Heplisav-B	Imovax Rabies IM
Intralipid IV	Ipratropium Bromide INH

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

Ipratropium-Albuterol INH	Magnesium Sulfate INJ
Methotrexate Sodium Oral Tab	Mycophenolate Mofetil Oral Cap
Mycophenolate Sodium Oral Tab	Nutrilipid IV
Octagam IV	Ondansetron
Ondansetron HCl Oral Tab	Pentamidine Isethionate INH
Potassium Chloride IV	prednisoLONE Oral Soln
prednisoLONE Sodium Phosphate Oral Soln	Privigen IV
Prograf	Prolastin-C IV
Prosol IV	Pulmozyme INH
RabAvert IM	Recombivax HB INJ
Sirolimus Oral Soln	Tacrolimus Oral Cap
Tobramycin INH	Travasol IV
TrophAmine IV	Voriconazole IV
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(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

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