Prominence Health

2026
Prior Authorization Criteria

ABALOPARATIDE

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: Yes

ABATACEPT

Affected Drugs:
Orencia
Orencia ClickJect

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:RHEUMATOID ARTHRITIS (RA), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA) AND JUVENILE PSORIATIC ARTHRITIS (JPSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.

Coverage Duration:FOR aGVHD: 12 MONTHS. FOR RA, PJIA, PSA, JPSA: 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 PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD WITH EXCEPTION FOR PATIENTS WITH MODERATE TO SEVERE DACTYLITIS. FOR ACUTE GRAFT VERSUS HOST DISEASE: ATTESTATION MEMBER IS TAKING IN COMBINATION WITH A CALCINEURIN INHIBITOR AND METHOTREXATE. PSA: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED. RENEWAL: RA, PJIA, PSA, JPSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

ABEMACICLIB

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

ABIRATERONE

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

ABIRATERONE SUBMICRONIZED

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

ACALABRUTINIB

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

ADAGRASIB

Affected Drugs:
Krazati

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 HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 1.) EVIDENCE OF KRAS G12C MUTATION AS DETERMINED BY AN APPROVED TEST 2.) PRIOR USE OF AT LEAST ONE SYSTEMIC THERAPY (E.G., ATEZOLIZUMAB, BEVACIZUMAB, CARBOPLATIN, CISPLATIN, NIVOLUMAB, PACLITAXEL, PEMETREXED, ETC.).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

ADALIMUMAB

Affected Drugs:
Humira (2 Pen)
Humira (2 Syringe)
Humira-CD/UC/HS Starter
Humira-Ped<40kg Crohns Starter
Humira-Ped>/=40kg Crohns Start
Humira-Ped>/=40kg UC Starter
Humira-Psoriasis/Uveit Starter

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:RA, PJIA, AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CD, UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPTHALMOLOGIST. HS: PRESCRIBED BY OR IN CONSULATION WITH A DERMATOLOGIST.

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

Other Criteria:INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): TRIAL OF OR CONTRAINDICATION TO ONE DMARD SUCH AS METHOTREXATE, LEFLUNOMIDE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS (AS): TRIAL OF OR CONTRAINDICATION TO AN NSAID. 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. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. UC AND CD: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED

RENEWAL: CD, UC, RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA (HS), UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

AFATINIB DIMALEATE

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

ALECTINIB

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

ALPELISIB

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

ALPHA 1-PROTEINASE INHIBITOR

Affected Drugs:
Glassia

Off-Label Uses:N/A

Exclusion Criteria:1) Immunoglobulin A (IgA) deficiency with antibodies against IgA

Required Medical Information:1) Diagnosis: alpha1-antitrypsin deficiency (AATD).

Age Restrictions:18 years of age or older

Prescription Order Restrictions: Geneticist, Endocrinologist, or Pulmonologist

Coverage Duration:12 months

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

AMIKACIN

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

ANAKINRA

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

Prerequisite Therapy Required: Yes

APALUTAMIDE

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

APOMORPHINE

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

APREMILAST

Affected Drugs:
Otezla
Otezla XR
Otezla/Otezla XR Initiation Pk

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: DIAGNOSIS OF PLAQUE PSORIASIS (PSO). FOR PEDIATRIC PATIENTS ONLY ACTUAL BODY WEIGHT AND DOCUMENTATION OF 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: Yes

ARIKAYCE

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

ASCIMINIB

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

ATOGEPANT

Affected Drugs:
Qulipta

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:RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH QULIPTA THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

AVACOPAN

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

AVAPRITINIB

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

AVATROMBOPAG

Affected Drugs:
Doptelet
Doptelet Sprinkle

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 OR PERSISTENT ITP: INITIAL: 4 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: Yes

AVMAPKI FAKZYNJA

Affected Drugs:
Avmapki Fakzynja Co-Pack

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: A) KRAS-mutated recurrent low-grade serous ovarian cancer (LGSOC), 2) Document: a) Prior systemic therapy was received (e.g. platinum-based regimen [e.g., cisplatin, carboplatin, oxaliplatin]).

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Hematologist/Oncologist, 2) Gynecologic Oncologist

Coverage Duration: End of Contract Year

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

AXATILIMAB-CSFR

Affected Drugs:
Niktimvo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: A) TREATMENT OF CHRONIC GRAFT-VERSUS-HOST DISEASE (CHRONIC GVHD). 2) DOCUMENT: I) FAILURE OF AT LEAST TWO PRIOR LINES OF SYSTEMIC THERAPY IN ADULT AND PEDIATRIC PATIENTS (E.G., PREDNISONE, METHOTREXATE, CYCLOSPORINE, TACROLIMUS, MYCOPHENOLATE, BELUMOSUDIL, IBRUTINIB, RUXOLITINIB, IF AVAILABLE), AND II) ACTUAL BODY WEIGHT OF AT LEAST 40KG.

Age Restrictions:N/A

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

AXITINIB

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

AZACITIDINE

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

AZTREONAM LYSINE

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

BEDAQUILINE FUMARATE

Affected Drugs:
Sirturo

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:24 WEEKS

Other Criteria:SIRTURO USED IN COMBINATION WITH AT LEAST 2 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

BELIMUMAB

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

BELUMOSUDIL MESYLATE

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

BELZUTIFAN

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

BEMPEDOIC ACID

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

BENRALIZUMAB

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

Prerequisite Therapy Required: Yes

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

BEROTRALSTAT

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

BEVACIZUMAB

Affected Drugs:
Avastin

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 CONTRAINIDCATION TO ZIRABEV WHERE INDICATIONS ALIGN. 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

BEVACIZUMAB-AWWB

Affected Drugs:
Mvasi

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 ZIRABEV WHERE INDICATIONS ALIGN. 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

BEVACIZUMAB-BVZR

Affected Drugs:
Zirabev

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 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

BEXAROTENE

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

BINIMETINIB

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

BOSUTINIB

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

BRIGATINIB

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

C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

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

C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

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

CABOZANTINIB

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

CABOZANTINIB S-MALATE - CABOMETYX

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

CANNABIDIOL

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: Yes

CAPIVASERTIB

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

CAPLACIZUMAB YHDP

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

CAPMATINIB

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

CARFILZOMIB

Affected Drugs:
Kyprolis

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 an oncologist or hematologist.

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

Other Criteria:INITIAL: 1) Diagnosis of Multiple Myeloma relapsed or refractory, as assessed by one of the following is the past 30 days: A) Serum M-protein greater than or equal to 0.5 g/dL, OR B) Urine M-protein greater than or equal to 200mg/24h, OR C) Serum free light chain (FLC) assay with involved FLC level greater than or equal to 10 mg/dL (100 mg/L) provided serum FLC ratio is abnormal, OR D) Member has progressive disease assessed within 60 days following the last dose of last anti-myeloma drug regimen received. 2) For Multiple Myeloma relapsed or refractory, it is used: A) In combination with dexamethasone or with lenalidomide plus dexamethasone in patients who have received one to three lines of therapy, or B) As a single agent in patients who have received one or more lines of therapy, OR C) In combination with Darzalex (daratumumab) or Darzalex Faspro (daratumumab/hyaluronidase-fihj) and dexamethasone in patients who have received one to three lines of therapy, OR D) In combination with Sarclisa (isatuximab-irfc) and dexamethasone in patients who have received one to three lines of therapy. 3) Request meets one of the following: A) Monotherapy: dose does not exceed 56 mg/m2 twice weekly each 28-day cycle, B) With dexamethasone and Revlimid: dose does not exceed 27 mg/m2 twice weekly 3 out of 4 weeks for twelve 28-day cycles, then 27 mg/m2 twice weekly 2 out of 4 weeks for the next six 28-day cycles for up to a total of 18 cycles, C) With dexamethasone with or without Darzalex dose does not exceed: i) 70 mg/m2 once weekly each 28-day cycle, OR ii) 56 mg/m2 twice weekly each 28-day cycle, D) With dexamethasone and Sarclisa: 56 mg/m2 twice weekly each 28-day cycle. 5) Prescribed carfilzomib (in combination with rituximab and dexamethasone) in the management of Waldenstrom macroglobulinemia in patients who have not previously received bortezomib or rituximab. RENEWAL: 1) Member is responding positively to 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.

CERITINIB

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

CLADRIBINE

Affected Drugs:
Cladribine (8 Tabs)
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

CLOBAZAM

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: Yes

CLOBAZAM-SYMPAZAN

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: Yes

COBIMETINIB FUMARATE

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

CORTICOTROPIN

Affected Drugs:
Acthar
Acthar Gel
Cortrophin
Cortrophin Gel

Off-Label Uses:N/A

Exclusion Criteria:NOT APPROVED FOR DIAGNOSTIC PURPOSES.

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.

Coverage Duration:INFANTILE SPASMS AND MS: 28 DAYS. OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS

Other Criteria:INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 1) DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS, AND 2) CONTINUES TO POSSESS CONTRAINDICATION TO IV CORTICOSTEROIDS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: Yes

Prerequisite Therapy Required: Yes

CRESEMBA

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

CRIZOTINIB

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

CYSTEAMINE HYDROCHLORIDE

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

DABRAFENIB MESYLATE

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

DACOMITINIB

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

DALFAMPRIDINE

Affected Drugs:
Dalfampridine ER

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:MULTIPLE SCLEROSIS (MM): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.

Coverage Duration:12 Months

Other Criteria:MM: INITIAL: WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

DANZITEN

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

DARATUMUMAB

Affected Drugs:
Darzalex
Darzalex Faspro

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 an oncologist or hematologist.

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

Other Criteria:INITIAL: Diagnosis of 1) newly diagnosed Multiple myeloma and one of the following: A) Ineligible for ASCT and in combination with one of the following: i) lenalidomide and dexamethasone OR ii) bortezomib, melphalan, and prednisone. B) Eligible for ASCT in combination with one of the following: i) bortzeomib, thalidomide, and dexamethasone OR ii) bortezomib, lenalidomide, and dexamethasone. 2) Relapsed/refractory Multiple myeloma and one of the following: A) In combination with dexamethasone and either lenalidomide, or bortezomib, or carfilzomib after 1 or more prior therapy. B) In combination with pomalidomide and dexamethasone after 2 or more prior therapies (only Darzalex), including both of the following (i and ii): i) An immunomodulatory agent (e.g. thalidomide, lenalidomide), and ii) A PI (e.g., ixazomib, bortezomib, carfilzomib). 3) Diagnosis of systemic light chain amyloidosis and one of the following: A) Darzalex Faspro in combination with bortezomib, cyclophosphamide, and dexamethasone. RENEWAL: Member is responding positively to therapy.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

DAROLUTAMIDE

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

DASATINIB

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

DATOPOTAMAB DERUXTECAN

Affected Drugs:
Datroway

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: A) UNRESECTABLE OR METASTATIC, HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE (IHC 0 , IHC 1+ OR ICH 2+/ISH-) BREAST CANCER. 2) DOCUMENT: A) FOR BREAST CANCER: I) PREVIOUS TREATMENT WITH ENDOCRINE-BASED THERAPY, II) PREVIOUS TREATMENT WITH AT LEAST ONE ADDITIONAL SYSTEMIC THERAPY FOR UNRESECTABLE OR METASTATIC DISEASE, III) POSITIVE HORMONE RECEPTOR (HR), AND IV) HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE (IHC 0, IHC 1+ OR IHC 2+/ISH-) BREAST CANCER.

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

DECITABINE/CEDAZURIDINE

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

DEFERASIROX

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: Yes

DEFERIPRONE

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: Yes

DEFLAZACORT

Affected Drugs:
Deflazacort
Kymbee

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:DUCHENNE MUSCULAR DYSTROPHY (DMD): DIAGNOSIS COMFIRMED BY GENETIC TESTING.

Age Restrictions:N/A

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

Coverage Duration:12 Months

Other Criteria:DMD: INITIAL: TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE), B) STEROID MYOPATHY HAS BEEN RULED OUT, C) DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E., PULMONARY OR CARDIAC FUNCTION).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

DEGARELIX ACETATE

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

DELAFLOXACIN

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: Yes

DENOSUMAB-XGEVA

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

DEUTETRABENAZINE

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

DICHLORPHENAMIDE

Affected Drugs:
Dichlorphenamide
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

DICLOFENAC EPOLAMINE

Affected Drugs:
Diclofenac Epolamine

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 Medically-accepted Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

DICLOFENAC TOPICAL

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: Yes

DIMETHYL FUMARATE

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

DIROXIMEL FUMARATE

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

DRONABINOL

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: Yes

DROXIDOPA

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

DUPILUMAB

Affected Drugs:
Dupixent

Off-Label Uses:N/A

Exclusion Criteria:N/A

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

Age Restrictions:N/A

Prescription Order Restrictions:ATOPIC DERMATITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP): PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. PN: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CSU: CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY

Coverage Duration:INITIAL: ATOPIC DERM, CRSWNP, CSU, EE, PN, BP: 6 MOS, ASTHMA, COPD: 12 MOS. RENEWAL: 12 MOS (ALL)

Other Criteria:INITIAL: ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, AND 3) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS, OR TOPICAL PDE4 INHIBITORS. 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, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR 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. PN: NO ADDITIONAL MEDICAL INFORMATION REQUIRED. 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. RENEWAL: ATOPIC DERMATITIS, CRSWNP, CSU: 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) 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

Prerequisite Therapy Required: Yes

DUVELISIB

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

EFGARTIGIMOD

Affected Drugs:
Vyvgart
Vyvgart Hytrulo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:GENERALIZED MYASTHENIA GRAVIS (GMG): 1) POSITIVE SEROLOGICAL TEST FOR ANTI-ACETYLCHOLINE RECEPTOR (ANTI-ACHR) ANTIBODIES, 2) DOCUMENTATION THAT INDIVIDUAL HAS A MYASTHENIA GRAVIS ACTIVITIES OF DAILY LIVING (MG-ADL) SCORE OF AT LEAST 5 OR HIGHER.

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:N/A

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

Other Criteria:GMG: 1) TRIAL AND INADEQUATE RESPONSE AFTER 3 MONTHS OR INTOLERANCE TO AN ACETYLCHOLINESTERASE INHIBITOR (PYRIDOSTIGMINE BROMIDE), IS ON A STABLE DOSE OF AN ACETYLCHOLINESTERASE INHIBITOR, OR CONTRAINDICATION TO ACETYLCHOLINESTERASE INHIBITORS. 2) TRIAL AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE IMMUNOSUPPRESSIVE AGENTS (INCLUDING BUT NOT LIMITED TO SYSTEMIC CORTICOSTEROIDS (PREDNISONE, PREDNISOLONE) FOR AT LEAST 3 MONTHS OR NON-STEROIDAL IMMUNOSUPPRESSANTS (AZATHIOPRINE, MYCOPHENOLATE) FOR NO MORE THAN 90 DAYS, IS ON A STABLE DOSE OF ONE OR MORE IMMUNOSUPPRESSIVE AGENTS (INCLUDING BUT NOT LIMITED TO SYSTEMIC CORTICOSTEROIDS OR NON-STEROIDAL IMMUNOSUPPRESSANTS), OR CONTRAINDICATION TO SYSTEMIC CORTICOSTEROIDS AND NON-STEROIDAL IMMUNOSUPPRESSANTS. RENEWAL: GMG: 1) REDUCTION IN SIGNS OR SYMPTOMS THAT IMPACT DAILY FUNCTION. 2) DOCUMENTATION IS PROVIDED TO SHOW IMPROVEMENT IN SYPMTOM SEVERITY AND DAILY FUNCTIONING COMPARED TO PRE-TREATMENT. 3) CONTINUED TREATMENT REQUIRED TO MAINTAIN RESPONSE OR TO REGAIN CLINICALLY MEANINGFUL 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.

EFLAPEGRASTIM *

Affected Drugs:
Rolvedon

* 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.

EFLORNITHINE

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

ELACESTRANT

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

ELAGOLIX SODIUM

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: Yes

ELAMIPRETIDE

Affected Drugs:
Forzinity

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Barth Syndrome, 2) Document: a) Actual Body Weight (weight MUST be at least 30 kg) 3) Renewals: a) Document actual body weight (weight MUST beat least 30 kg)

Age Restrictions:N/A

Prescription Order Restrictions:1) Geneticist, 2) Physician specialized in metabolic or genetic disorders, 3) Cardiologist, 4) Endocrinologist, 5) Hematologist/Oncologist, 6) Neurologist

Coverage Duration:12 MONTHS

Other Criteria:1) Not approved for use in neonates due to risk of benzyl alcohol toxicity.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

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

ELIGLUSTAT TARTRATE

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

ELTROMBOPAG

Affected Drugs:
Promacta

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

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

Coverage Duration:ITP: INITIAL: 2 MO. RENEW: 12 MO. HCV: 12 MO. SEVERE APLASTIC ANEMIA: 12 MO.

Other Criteria:INITIAL: CHRONIC OR PERSISTENT IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PATIENT IS UNABLE TO TAKE TABLET FORMULATION. ITP: RENEWAL: PATIENT HAS SHOWN A CLINICAL RESPONSE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

ENASIDENIB

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

ENCORAFENIB

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

ENDOTHELIN RECEPTOR ANTAGONISTS

Affected Drugs:
Ambrisentan
Bosentan
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

ENSARTINIB

Affected Drugs:
Ensacove

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Patient has locally advanced or metastatic NSCLC. 2) Document: A) Documentation patient has ALK-positive NSCLC.

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Hematologist/Oncologist, 2) Pulmonologist

Coverage Duration:12 MONTHS

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

ENTRECTINIB

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

ENZALUTAMIDE

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

ERDAFITINIB

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

ERENUMAB-AOOE

Affected Drugs:
Aimovig

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:MIGRAINE PREVENTION: RENEWAL: EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

ERLOTINIB

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

ERYTHROPOIESIS STIMULATING AGENTS - RETACRIT

Affected Drugs:
Retacrit

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE THERAPY, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL BETWEEN 10G/DL LESS THAN OR EQUAL TO 13G/DL. RENEWAL: CKD: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration:ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS. SURGERY:1 MONTH.

Other Criteria:RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. 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.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

ETANERCEPT

Affected Drugs:
Enbrel
Enbrel Mini
Enbrel SureClick

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:RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS (PSA): 18 YEARS OR OLDER. JUVENILE PSORIATIC ARTHRITIS (JPSA): 2 YEARS OR OLDER.

Prescription Order Restrictions:RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA AND JPSA: PRESCRIBED BY OR GIVEN 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: 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 IS REQUIRED. PJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. 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. PSA: NO ADDITIONAL MEDICAL INFORMATION REQUIRED. RENEWAL: RA, PJIA, PSA, AS, PSO, JPSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

EVEROLIMUS

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: Yes

FECAL MICROBIOTA

Affected Drugs:
Vowst

Off-Label Uses:N/A

Exclusion Criteria:ACTIVE CDI TREATMENT OR FIRST CDI OCCURRENCE.

Required Medical Information:1) DIAGNOSIS: PREVENTION OF RECURRENCE OF CLOSTRIDIOIDES DIFFICILE INFECTION (CDI) 2) DOCUMENT: A) DIAGNOSIS OF AT LEAST GREATER THAN OR EQUAL TO 2 RECURRENT EPISODE OF CDI [RECURRENT CDI IS DEFINED AS THE RECURRENCE OF DIARRHEA AND A CONFIRMATORY POSITIVE CDI TEST WITHIN 8 WEEKS AFTER TREATMENT OF AN INITIAL EPISODE (GREATER THAN OR EQUAL TO 3 TOTAL CDI EPISODES)], B) PRESCRIBER DOCUMENTATION INDICATING ANTIBIOTIC REGIMEN THE PATIENT IS RECEIVING AND THAT THE CURRENT EPISODE OF CDI IS CONTROLLED (LESS THAN 3 UNFORMED/LOOSE STOOLS/DAY FOR 2 CONSECUTIVE DAYS), C) POSITIVE STOOL TEST FOR C. DIFFICILE WITHIN 30 DAYS BEFORE PRIOR AUTHORIZATION REQUEST.

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INTERNIST, OR INFECTIOUS DISEASE SPECIALIST.

Coverage Duration:1 week

Other Criteria:ADMINISTRATION WILL OCCUR 24-96 HOURS FOLLOWING COMPLETION OF ANTIBIOTIC COURSE FOR CDI TREATMENT.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

FEDRATINIB

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: Yes

FENFLURAMINE

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

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

Affected Drugs:
fentaNYL Citrate

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:CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

FEZOLINETANT

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: Yes

FILGRASTIM

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: Yes

FINERENONE

Affected Drugs:
Kerendia

Off-Label Uses:N/A

Exclusion Criteria:1) Concomitant use with strong CYP3A4 inhibitors, 2) Patients with adrenal insufficiency.

Required Medical Information:1) Diagnosis: A) Chronic kidney disease due to type 2 diabetes mellitus, B) Heart Failure with Left Ejection Fraction greater than or equal to 40% 2) Document: a) patient is taking Kerendia in combination with an angiotensin-converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) at maximum tolerated doses or documentation has been provided that the patient is unable to tolerate ACEi or ARB

Age Restrictions:18 years of age or older

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

FINGOLIMOD

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

FLUTAMIDE

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

FOSTAMATINIB

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

FRUQUINTINIB

Affected Drugs:
Fruzaqla

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 METASTATIC COLORECTAL CANCER (MCRC): A) PRIOR TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-CONTAINING CHEMOTHERAPY, AND ANTI-VEGF THERAPY (E.G., BEVACIZUMAB), AND IF RAS WILD TYPE, AN ANTI-EGFR THERAPY (E.G. ERBITUX, VECTIBIX)

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

FUTIBATINIB

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

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 HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:UNRESECTABLE, LOCALLY ADVANCED OR METASTATIC ICCA HARBORING FGFR2 GENE FUSIONS OR OTHER REARRANGEMENTS: 1) FIBROBLAST GROWTH FACTOR RECEPTOR 2 (FGFR2) FUSION OR OTHER REARRANGEMENT 2) PREVIOUSLY USED THERAPIES (E.G GEMCITABINE AND CISPLATIN OR DURVALUMAB, GEMCITABINE AND CISPLATIN) 3) DISEASE IS UNRESECTABLE AND LOCALLY ADVANCED OR METASTATIC.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

GALCANEZUMAB-GNLM

Affected Drugs:
Emgality
Emgality (300 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:INITIAL: MIGRAINES: 6 MOS. CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL INDICATIONS): 12 MONTHS.

Other Criteria:INITIAL FOR MIGRAINES AND CLUSTER HEADACHE: NO STEP. RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY. RENEWAL FOR EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

GANAXOLONE

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

GEFITINIB

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

GEPIRONE

Affected Drugs:
Exxua
Exxua Titration Pack

Off-Label Uses:N/A

Exclusion Criteria:1) prolonged QTc interval greater than 450 msec, 2) congenital long QT syndrome, 3) concomitant use of strong CYP3A4 inhibitors or 4) severe hepatic impairment, 5) Use with a MAOI or within 14 days of stopping treatment with a MAOI.

Required Medical Information:1) Diagnosis: Major Depressive Disorder, 2) Document: The patient has tried and failed at least two of the following: Citalopram, Duloxetine, Escitalopram, Fluoxetine, Fluvoxamine, Sertraline, Bupropion or Bupropion ER, Venlafaxine or Venlafaxine ER .

Age Restrictions:18 years of age or older

Prescription Order Restrictions: Psychiatrist

Coverage Duration: End of Contract Year

Other Criteria:1) Patients = 65 years of age : maximum daily dose is 36.3 mg per day, 2) Patient will NOT take a monoamine oxidase inhibitor (MAOI) within 14 days of taking Exxua

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

GILTERITINIB

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

GLASDEGIB

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

GLATIRAMER ACETATE

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

GLECAPREVIR/PIBRENTASVIR

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

GLUCAGONLIKE PEPTIDE 1 RECEPTOR AGONIST

Affected Drugs:
Mounjaro
Ozempic
Ozempic (0.25 or 0.5 MG/DOSE)
Ozempic (1 MG/DOSE)
Ozempic (2 MG/DOSE)
Rybelsus
Rybelsus (Formulation R2)
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

GLYCEROL PHENYLBUTYRATE

Affected Drugs:
Glycerol Phenylbutyrate
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: Yes

GUSELKUMAB

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

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:PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CD, UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.

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

Other Criteria:INITIAL: PSA: NO ADDITIONAL MEDICAL INFORAMTION REQUIRED. PSO: TRIAL OF OR CONTRAINDICATION ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED. RENEWAL: CD, UC, PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

HERNEXEOS

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: Yes

HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

Affected Drugs:
Morphine Sulfate (Concentrate)

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:OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.

Other Criteria:1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

HIGH RISK MEDICATIONS

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

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:PROVIDER ACKNOWLEDGEMENT THAT MEDICATION IS A HRM IN THE ELDERLY AND THAT THE PATIENT HAS FAILED AND/OR TRIED AT LEAST ONE NON-HIGH RISK ALTERNATIVE.

Age Restrictions:PA APPLIES TO PATIENTS 65 YEARS OF AGE OR OLDER.

Prescription Order Restrictions:N/A

Coverage Duration:1) FOR CYCLOBENZAPRINE ONLY: 21 DAYS, RENEWALS: 21 DAYS. 2) ALL OTHER DRUGS: 12 MONTHS

Other Criteria:FOR CYCLOBENZAPRINE, DICYCLOMINE, AND SCOPOLAMINE TRANSDERMAL: ONLY PROVIDER ATTESTATION OF RISKS AND BENEFITS OF THERAPY IS REQUIRED.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

HIGH RISK MEDICATIONS 2

Affected Drugs:
PARoxetine HCl

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:PROVIDER ACKNOWLEDGEMENT THAT MEDICATION IS A HRM IN THE ELDERLY AND THAT THE PATIENT HAS FAILED AND/OR TRIED AT LEAST ONE NON-HIGH RISK ALTERNATIVE.

Age Restrictions:PA APPLIES TO PATIENTS 65 YEARS OF AGE OR OLDER.

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: Yes

IBRUTINIB

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

IBTROZI

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

ICATIBANT

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

IDELALISIB

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

IMATINIB MESYLATE

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

IMLUNESTRANT

Affected Drugs:
Inluriyo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Treatment of adults with ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy (i.e. letrozole, exemestane, anastrozole, fulvestrant) with or without a CDK 4/6 inhibitor: Kisqali (ribocitinib), Ibrance (palbociclib), Verzenio (abemaciclib) 2) Document biomarker test results evidencing: ER-positive, HER2-negative, ESR1-mutation.

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Hematologist/Oncologist, 2) Gynecologist

Coverage Duration: End of Contract Year

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

INAVOLISIB

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

INTERFERON GAMMA-1B

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

INTERFERONS FOR MULTIPLE SCLEROSIS

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

IVACAFTOR

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

IVOSIDENIB

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

IXAZOMIB

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

KISUNLA

Affected Drugs:
Kisunla

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Mild cognitive impairment or mild dementia stage of Alzheimer's Disease. 2) Document: A) Obtain baseline brain magnetic resonance imaging (MRI) prior to initiating treatment with KISUNLA B) Confirmed presence of amyloid beta pathology prior to initiating treatment (i.e. positive amyloid PET scan or detection of amyloid from cerebrospinal fluid). C) Must have one or more of the following scores at baseline on any of the following assessment tools: a) Mini-Mental Examination Status (MMSE) score of 21-30 or b) Montreal Cognitive Assessment (MoCA) score of greater than or equal to 16 or c) Clinical Dementia Rating (CDR) Global Score of 0.5.

Age Restrictions:18 years of age and older

Prescription Order Restrictions: For first prescription: Neurologists, 2) For renewals: Neurologists or Geriatricians

Coverage Duration:12 months

Other Criteria: Validate if injectable infusions are covered under the Pharmacy benefit. Normally these drugs are not covered under the Pharmacy benefit, validate coverage.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

L-GLUTAMINE

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

LANADELUMAB

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

LANREOTIDE

Affected Drugs:
Lanreotide Acetate

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: DIAGNOSIS OF ACROMEGALY: 1) INADEQUATE RESPONSE TO SURGERY OR RADIOTHERAPY, OR SURGERY OR RADIOTHERAPY IS NOT AN OPTION, 2) BASELINE GROWTH HORMONE (GH) AND IGF-I BLOOD LEVELS, 3) WILL NOT BE USED IN COMBINATION WITH ORAL OCTREOTIDE.

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:N/A

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

Other Criteria:INITIAL: DIAGNOSIS OF CARCINOID SYNDROME: 1) REDUCE THE FREQUENCY OF SHORT-ACTING SOMATOSTATIN ANALOG RESCUE THERAPY. DIAGNOSIS OF GASTROENTEROPANCREATIC NEUROENDOCRINE TUMORS (GEP-NETS): 1) DISEASE IS UNRESECTABLE, LOCALLY ADVANCED OR METASTATIC, WELL OR MODERATELY DIFFERENTIATED. RENEWAL: ALL INDICATIONS: 1) IMPROVED DISEASE RESPONSE FROM BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

LAPATINIB

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

LAROTRECTINIB

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: Yes

LAZERTINIB

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

LEDIPASVIR-SOFOSBUVIR

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

LENALIDOMIDE

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

LENVATINIB

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

LEQVIO

Affected Drugs:
Leqvio

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: A) Treatment of hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH). 2) Document (only for first prescription): A) Baseline LDL-C Level greater than 70 mg/dL (lipid panel results)

Age Restrictions:18 years of age or older

Prescription Order Restrictions: Cardiologist, Endocrinologist, Internist, Lipid Disorders Specialist, or Vascular Surgeon

Coverage Duration:12 months

Other Criteria:N/A

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

LETERMOVIR

Affected Drugs:
Prevymis

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:200 Days

Other Criteria:CYTOMEGALOVIRUS (CMV) PROPHYLAXIS IN HEMATOPOIETIC CELL TRANSPLANT RECIPIENTS: THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANTATION. CMV PROPHYLAXIS IN KIDNEY TRANSPLANT RECIPIENTS: THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 7 POST TRANSPLANTATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

LEVODOPA

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

LIDOCAINE

Affected Drugs:
Lidocaine
Lidocaine HCl
Tridacaine II
ZTlido

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: Part B vs. Part D evaluation also applies to Lidocaine 5% ointment and 4% solution.(*)

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.

LIDOCAINE PRILOCAINE

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

LOMITAPIDE

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: Yes

LOMUSTINE

Affected Drugs:
Gleostine
Lomustine

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

LORLATINIB

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

LOTILANER

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

LUMACAFTOR-IVACAFTOR

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

LUSUTROMBOPAG

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

MARIBAVIR

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

MEPOLIZUMAB

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 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.

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

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

MIDOSTAURIN

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

MIFEPRISTONE

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

MIGALASTAT

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

MIGLUSTAT

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

MILTEFOSINE

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

MIRDAMETINIB

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

MITAPIVAT

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

MOBOCERTINIB

Affected Drugs:
Exkivity

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

MODEYSO

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) Documented progressive disease following prior therapy (i.e. radiotherapy, chemotherapy) 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

MOMELOTINIB

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

MOSUNETUZUMAB-AXGB

Affected Drugs:
Lunsumio

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 HEMATOLOGIST OR ONCOLOGIST

Coverage Duration:12 MONTHS

Other Criteria:RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA (FL): 1) PRIOR USE OF AT LEAST TWO LINES OF SYSTEMIC THERAPY (E.G. RITUXIMAB, CYCLOPHOSPHAMIDE, VINCRISTINE, CORTICOSTEROIDS, LENALIDOMIDE, DUVELISIB, ETC.)

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

NERATINIB MALEATE

Affected Drugs:
Nerlynx

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:EARLY-STAGE TUMOR (STAGE I-III) AND THE MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

NILOTINIB

Affected Drugs:
Nilotinib D-Tartrate
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, OR F359V/C/I

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

NINTEDANIB

Affected Drugs:
Nintedanib Esylate
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 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: Yes

NIRAPARIB

Affected Drugs:
Zejula

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:RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: ZEJULA WILL BE USED AS MONOTHERAPY AND IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

NIRAPARIB ABIRATERONE

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

NIROGASESTAT

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

NITISINONE

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: Yes

OBETICHOLIC ACID

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: Yes

OCRELIZUMAB

Affected Drugs:
Ocrevus
Ocrevus Zunovo

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:RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. 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

OFATUMUMAB-SQ

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

OLANZAPINE/SAMIDORPHAN

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: Yes

OLAPARIB

Affected Drugs:
Lynparza

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:RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: 1) MEDICATION WILL BE USED AS MONOTHERAPY, AND 2) PATIENT HAS COMPLETED TWO OR MORE LINES OF PLATINUM-BASED CHEMOTHERAPY. ADVANCED GERMLINE BRCA-MUTATED OVARIAN CANCER: 1) PATIENT HAS COMPLETE OR PARTIAL RESPONSE TO PLATINUM-BASED CHEMOTHERAPY. 2) MEDICATION WILL BE USED AS MONOTHERAPY. 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. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

OLUTASIDENIB

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

OMALIZUMAB

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: Yes

OSIMERTINIB

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

PACRITINIB

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

PALBOCICLIB

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

PASIREOTIDE DIASPARTATE

Affected Drugs:
Signifor

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:N/A

Prescription Order Restrictions:CUSHINGS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.

Coverage Duration:12 Months

Other Criteria:RENEWAL: CD: PATIENT CONTINUES TO HAVE IMPROVEMENT OF CD AND MAINTAINS TOLERABILITY TO SIGNIFOR.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

PAZOPANIB

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

PCSK9

Affected Drugs:
Praluent
Repatha
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

PDE5 INHIBITORS PAH

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

PEGFILGRASTIM

Affected Drugs:
Fulphila
Neulasta
Nyvepria
Udenyca
Udenyca Onbody

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: Yes

PEGLOTICASE

Affected Drugs:
Krystexxa

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Clinical chart notes show submission of laboratory values demonstrating baseline serum uric acid level greater than 6 mg/dL.

Age Restrictions:N/A

Prescription Order Restrictions:N/A

Coverage Duration: Initial: 12 MONTHS. Renewal: 12 MONTHS

Other Criteria: Initial: Chronic Gout: 1) Member has symptomatic gout as defined by one of the following: History of at least 2 gout flares in the previous 12 months, at least 1 gouty tophus, or chronic gouty arthropathy. 2) Member has a history of contraindication, intolerance, or treatment failure (i.e., failure to normalize uric acid to less than 6 mg/dL) after 3 months of therapy (at the maximally medically appropriate dose) with both of the following: allopurinol and febuxostat. 3) Prescriber attestation that serum uric acid levels will be monitored prior to each infusion and that discontinuation of treatment will be considered if preinfusion levels increase above 6 mg/dL. Renewal: 1) You are currently receiving Krystexxa. 2) Documentation of a positive clinical response. 3) Member had two consecutive uric acid levels above 6 mg/dL after initiating treatment.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

PEGVALIASE-PQPZ

Affected Drugs:
Palynziq

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.

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

PEGVISOMANT

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

PEMBROLIZUMAB

Affected Drugs:
Keytruda
Keytruda Qlex

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

PEMETREXED

Affected Drugs:
Axtle
Pemrydi RTU

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

PEMIGATINIB

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

PENICILLAMINE

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 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.

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

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

PEXIDARTINIB

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

PIMAVANSERIN

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

PIRFENIDONE

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

PIRTOBRUTINIB

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

POMALIDOMIDE

Affected Drugs:
Pomalidomide
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

PONATINIB

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

POSACONAZOLE

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: Yes

PRALSETINIB

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

PRAMLINTIDE

Affected Drugs:
SymlinPen 120
SymlinPen 60

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL

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: Yes

PYRIMETHAMINE

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

QUININE SULFATE

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

QUIZARTINIB

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

REGORAFENIB

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

RELUGOLIX

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

REMICADE

Affected Drugs:
Remicade

Off-Label Uses:N/A

Exclusion Criteria: Doses greater than 5 mg/kg in moderate to severe heart failure.

Required Medical Information:1) Diagnosis: A) Crohn's Disease (CD): i) Reduce signs/symptoms and induce/maintain remission in mod–severe disease unresponsive to conventional therapy, ii) Reduce draining enterocutaneous/rectovaginal fistulas and maintain fistula closure in fistulizing disease. B) Ulcerative Colitis (UC): Reduce signs/symptoms, induce/maintain remission and mucosal healing, and eliminate corticosteroid use in mod–severe disease unresponsive to conventional therapy. C) Rheumatoid Arthritis (RA) with Methotrexate (MTX): Reduce signs/symptoms, inhibit structural damage, and improve physical function in mod–severely active disease. D) Ankylosing Spondylitis (AS): Reduce signs/symptoms in active disease. E) Psoriatic Arthritis (PsA): Reduce signs/symptoms, inhibit progression, and improve function. F) Plaque Psoriasis (PsO): Treat chronic severe (extensive/disabling) PsO requiring systemic therapy when other systemic options are less appropriate. 2) Document: A) CD: i) Failure of 1 conventional drug, ii) Prior use of 2 formulary preferred agents, iii) If available, prior use of 1 non preferred agent. B) UC: i) Failure of 1 conventional drug, ii) Prior use of 2 preferred agents. C) RA: i) Use with MTX, ii) Failure of 1 DMARD, iii) Prior use of 2 preferred agents, iv) If available, prior use of 1 nonpreferred. D) AS: i) Failure of 1 NSAID, ii) Prior use of 2 preferred agents, iii) If available, 1 nonpreferred. E) PsA: i) Failure of 1 DMARD, ii) Prior use of 2 preferred agents. F) PsO: i) greater than or equal to 10% BSA or crucial areas involved (hands/feet/face/scalp/genitals), ii) Prior use of 1 conventional agent, iii) Prior use of 2 preferred agents. G) All Indications: i) Document actual body weight (weight based dosing), ii) For biologic naive patients: clinician certification of TB status or TB test dated within 12 months prior to starting therapy. 3) Biosimilar required for naive patients. Other agents require documented failure, intolerance, or contraindication to a biosimilar.

Age Restrictions:1) For CD and UC: 6 years of age or older. 2) For all other indications: 18 years of age or older.

Prescription Order Restrictions:1) For PsO: Dermatologist. 2) For CD and UC: Gastroenterologist. 3) For RA, AS: Rheumatologist. 4) For PsA: Dermatologist or Rheumatologist.

Coverage Duration:12 months

Other Criteria:N/A

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: Yes

REPOTRECTINIB

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

REVCOVI

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

REVUMENIB

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

REZDIFFRA

Affected Drugs:
Rezdiffra

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: 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 (NITs), 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

RIABNI

Affected Drugs:
Riabni

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:N/A

Age Restrictions:RHEUMATOID ARTHRITIS (RA), CHRONIC LYMPHOCYTIC LEUKEMIA (CLL), NON-HODGKIN'S LYMPHOMA (NHL): 18 YEARS OR OLDER. GRANULOMATOSIS WITH POLYANGIITIS (GPA) (WEGENER'S GRANULOMATOSIS), MICROSCOPIC POLYANGIITIS (MPA): 2 YEARS OR OLDER.

Prescription Order Restrictions:RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. CHRONIC LYMPHOCYTIC LEUKEMIA (CLL), NON-HODGKIN'S LYMPHOMA (NHL): PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.

Coverage Duration:FOR NHL, GPA, MPA: 12 MONTHS. FOR RA, CLL: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria:FOR GPA, MPA: CONCURRENT USE OF GLUCOCORTICOIDS. INITIAL RA: TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG), SUCH AS METHOTREXATE DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. FOR CLL: CONCURRRENT CHEMOTHERAPY (E.G., FLUDARABINE, CYCLOPHOSPHAMIDE). RENEWAL: RA: EXPERIENCED OR MAINTAINED A 20 PERCENT OR GREATER IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

RIBOCICLIB

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

RIFAXIMIN

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: Yes

RIMEGEPANT

Affected Drugs:
Nurtec

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: ACUTE MIGRAINE TREATMENT: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). RENEWAL: ACUTE MIGRAINE TREATMENT: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH, OR 2) REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

RIOCIGUAT

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

RIPRETINIB

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

RISANKIZUMAB-RZAA

Affected Drugs:
Skyrizi
Skyrizi Pen

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:PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CD, UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.

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

Other Criteria:INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: NO ADDITIONAL MEDICAL IMFORAMTION REQUIRED. CD: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED. RENEWAL: CD, UC, PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

RISDIPLAM

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

ROMOSOZUMAB

Affected Drugs:
Evenity

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information: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 SUCH AS NAFARELIN, ETC.). 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) THERAPEUTIC FAILURE OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.

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: Yes

ROPEGINTERFERON ALFA-2B-NJFT

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

ROZANOLIXIZUMAB-NOLI

Affected Drugs:
Rystiggo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:GENERALIZED MYASTHENIA GRAVIS (GMG): 1) POSITIVE SEROLOGICAL TEST FOR ANTI-ACETYLCHOLINE RECEPTOR (ANTI-ACHR) ANTIBODIES OR ANTI-MUSCLE-SPECIFIC TYROSINE KINASE (MUSK) ANTIBODIES POSITIVE TEST RESULTS, 2) DOCUMENTATION OF PRIOR AND/OR CURRENT TREATMENTS PATIENT HAS USED FOR MYASTHENIA GRAVIS

Age Restrictions:18 YEARS OF AGE OR OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH NEUROLOGIST

Coverage Duration:6 Weeks

Other Criteria:PART B VS D EVALUATION ALSO APPLIES. SUBSEQUENT CYCLES CAN BE ADMINISTERED BASED ON CLINICAL EVALUATION. THE SAFETY OF INITIATING SUBSEQUENT CYCLES SOONER THAN 63 DAYS FROM THE START OF THE PREVIOUS TREATMENT CYCLE HAS NOT BEEN ESTABLISHED.(*)

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

RUCAPARIB

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

RUXOLITINIB

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

SECUKINUMAB

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

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. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).

Age Restrictions:N/A

Prescription Order Restrictions:PSO, HS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

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

Other Criteria:INITIAL: 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. PSA: FOR BIOLOGIC THERAPY-NAIVE PATIENTS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG). AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. RENEWAL: PSO, PSA, AS, NR-AXSPA, ERA, HS: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

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

SELEXIPAG

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: Yes

SELINEXOR

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

SELPERCATINIB

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

SELUMETINIB

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

SEVABERTINIB

Affected Drugs:
Hyrnuo

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: A) Locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC). 2) Document: A) For NSCLC: 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:12 months

Other Criteria:1) 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: Yes

SIPONIMOD

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

SIROLIMUS PROTEIN-BOUND

Affected Drugs:
Fyarro

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

SODIUM OXYBATE

Affected Drugs:
Xyrem

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 ONE OF THE FOLLOWING SPECIALISTS: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE

Coverage Duration:INITIAL 6 MONTHS. RENEWAL: 12 MONTHS

Other Criteria:ALL INDICATIONS: INITIAL: THE PATIENT IS NOT CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS. EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: FOR PATIENTS 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, PITOLISANT OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. FOR PATIENTS 7 TO 17 YEARS OF AGE: NO OTHER MEDICAL INFORMATION IS REQUIRED FOR EDS IN NARCOLEPSY. RENEWAL: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

SOFOSBUVIR/VELPATASVIR

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

SOLRIAMFETOL

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: Yes

SOMATROPIN - NORDITROPIN

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

SOMATROPIN - SEROSTIM

Affected Drugs:
Serostim

Off-Label Uses:N/A

Exclusion Criteria:ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.

Required Medical Information:INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.

Age Restrictions:N/A

Prescription Order Restrictions:HIV/WASTING: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.

Coverage Duration:12 Months

Other Criteria:HIV/WASTING: INITIAL: DIAGNOSIS, RENEWAL: CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

SONIDEGIB

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

SORAFENIB TOSYLATE

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

SOTORASIB

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

STIRIPENTOL

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

SUNITINIB MALATE

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: Yes

TACROLIMUS XR

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

TADALAFIL BPH

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

TAFAMIDIS

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

TALAZOPARIB

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: Yes

TASIMELTEON

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

TAZEMETOSTAT

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

TECLISTAMAB-CQYV

Affected Drugs:
Tecvayli

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 MULTIPLE MYELOMA: 1.) THERAPEUTIC FAILURE TO AT LEAST FOUR PRIOR LINES OF THERAPY, INCLUDING AT LEAST ONE PROTEASOME INHIBITOR (E.G., BORTEZOMIB, CARFILZOMIB, IXAZOMIB), ONE IMMUNOMODULATORY AGENT (E.G., THALIDOMIDE, LENALIDOMIDE, POMALIDOMIDE), AND ONE CD38-DIRECTED MONOCLONAL ANTIBODY (E.G., DARATUMUMAB).

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

TEDUGLUTIDE

Affected Drugs:
Gattex

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 IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

TELISOTUZUMAB VEDOTIN-TLLV

Affected Drugs:
Emrelis

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

TELOTRISTAT

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

TEPOTINIB

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

TEPROTUMUMAB-TRBW

Affected Drugs:
Tepezza

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

TERIFLUNOMIDE

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

TESAMORELIN

Affected Drugs:
Egrifta SV
Egrifta WR

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

TESTOSTERONE

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

TETRABENAZINE

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

TEZACAFTOR/IVACAFTOR

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

THALIDOMIDE

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

TISLELIZUMAB

Affected Drugs:
Tevimbra

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC ESOPHAGEAL SQUAMOUS CELL CARCINOMA (ESCC). 2) DOCUMENT: DISEASE PROGRESSION FOLLOWING AT LEAST ONE SYSTEMIC THERAPY [E.G., FLUOROPYRIMIDINE (FLUOROURACIL OR CAPECITABINE), OXALIPLATIN OR CISPLATIN, ETC.] THAT DID NOT INCLUDE A PD-1 (I.E., NIVOLUMAB, PEMBROLIZUMAB, ETC.), PD-L1 (I.E., DURVALUMAB, ETC.), OR CTLA-4 (I.E., IPILIMUMAB, ETC.) DIRECTED THERAPY FOR RECURRENT LOCALLY ADVANCED OR METASTATIC ESCC.

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:PART D VS. PART B EVALUATION ALSO APPLIES.(*)

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.

TIVOZANIB

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

TOFACITINIB

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: Yes

TOLVAPTAN

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

TOPICAL TRETINOIN

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: Yes

TOVORAFENIB

Affected Drugs:
Ojemda

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: FOR THE TREATMENT OF PATIENTS 6 MONTHS OF AGE AND OLDER WITH RELAPSED OR REFRACTORY PEDIATRIC LOW_GRADE GLIOMA (PLGG). 2) DOCUMENT: A) BRAF FUSION OR REARRANGEMENT OR BRAF V600 MUTATION B) DOCUMENTATION OF PATIENT HAS RECEIVED AT LEAST ONE SYSTEMIC THERAPY (TAFINLAR PLUS MEKINIST) PRIOR OR CURRENT TREATMENTS PATIENT HAS USED FOR PLGG AND C) PATIENTS ACTUAL BODY WEIGHT AND BODY SURFACE AREA (DOSING BASED ON BODY SURFACE AREA).

Age Restrictions:6 MONTHS OF AGE AND 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: Yes

TRAMETINIB

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

TREMELIMUMAB-ACTL

Affected Drugs:
Imjudo

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:LOCALLY ADVANCED UNRESECTABLE AND/OR METASTATIC HEPATOCELLULAR CARCINOMA (UHCC): 1) PRESCRIBED IN COMBINATION WITH DURVALUMAB AS FIRST-LINE THERAPY ONLY. 2) CHILD-PUGH SCORE CLASS A. 3) PRIOR HISTORY OF PRIOR SYSTEMIC TREATMENT, INCLUDING PD-1/PD-L1 USE, 4) ECOG PERFORMANCE STATUS OF 0-1, 5) RATIONAL OF WHY ATEZOLIZUMAB AND BEVACIZUMAB COMBINATION OR DURVALUMAB AS MONOTHERAPY IS NOT APPROPRIATE AS MONOTHERAPY. METASTATIC NON-SMALL-CELL LUNG CARCINOMA (NSCLC): 1) PRESCRIBED IN COMBINATION WITH DURVALUMAB AND PLATINUM-BASED CHEMOTHERAPY IN PATIENTS WITH NO EGFR OR ALK GENOMIC TUMOR ABERRATIONS.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

TREOSULFAN

Affected Drugs:
Grafapex

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: A) ACUTE MYELOID LEUKEMIA (AML) AS A PREPARATIVE REGIMEN FOR ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION (ALLOHSCT) B) MYELODYSPLASTIC SYNDROME (MDS) AS A PREPARATIVE REGIMEN FOR ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION AND II) ACTUAL BODY WEIGHT OR BSA

Age Restrictions:1 YEARS OF AGE OR OLDER

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

TRIENTINE

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: Yes

TRIFLURIDINE/TIPIRACIL

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

TUCATINIB

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

TYENNE

Affected Drugs:
Tyenne

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: A) Treatment of moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs), B) Treatment of giant cell arteritis (GCA), C) Treatment of active polyarticular juvenile idiopathic arthritis (PJIA), D) Treatment of active systemic juvenile idiopathic arthritis (SJIA), E) Cytokine Release Syndrome (CRS). 2) Document: A) For RA: i) Therapeutic failure to at least one disease-modifying anti-rheumatic drugs (DMARDs) (e.g., methotrexate, hydroxychloroquine, leflunomide), ii) Prior use of at least one formulary preferred drugs (e.g. Enbrel, Humira, Orencia, Rinvoq, Xeljanz, if available B) For GCA, CRS, PJIA, SJIA: No additional medical information is required. D) For all indications: Only for biologic therapy-naïve patients: Physician's certification stating tuberculosis (TB) status or result of a TB detection test with a reading date less than 12 months before the start of therapy.

Age Restrictions:1) For RA and GCA: 18 years of age and older, 2) For CRS, PJIA and SJIA : 2 years of age and older

Prescription Order Restrictions:1) For CRS: Hematologist/Oncologist, 2) For all other indications: Rheumatologist

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: Yes

UBROGEPANT

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: Yes

ULTOMIRIS

Affected Drugs:
Ultomiris

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:INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS.

Other Criteria:INITIAL: 1) Diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) and meets the following: A) Flow cytometry shows detectable GPI-deficient hematopoietic clones or greater than or equal to 5% PNH cells, B) Member has one of the following: i) History of greater than or equal to 1 transfusion in the past 24 months with documentation of hemoglobin less than or equal to 7 g/dL in members without anemia symptoms or hemoglobin less than or equal to 10 g/dL in members with anemia symptoms, or ii) History of thrombosis. RENEWAL: 1) PNH: Member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: Improved measures of intravascular hemolysis (e.g., normalization of lactate dehydrogenase [LDH]), Reduced need for red blood cell transfusions, Increased or stabilization of hemoglobin levels, Less fatigue, Improved health-related quality of life, or Fewer thrombotic events.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

UPADACITINIB

Affected Drugs:
Rinvoq
Rinvoq LQ

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).

Age Restrictions:N/A

Prescription Order Restrictions:RHEUMATOID ARTHRITIS (RA), GIANT CELL ARTERITIS (GCA) AND ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ATOPIC DERMATITIS (AD): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. FOR CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): GASTROENTEROLOGIST.

Coverage Duration:INITIAL: RA,PSA,AS,CD,UC,NR-AXSPA,PJIA,AD,GCA: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria: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: TRIAL OF OR CONTRAINDICATION TO ONE DMARD AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS. ATOPIC DERMATITIS: TRIAL OF A HIGH OR SUPER HIGH POTENCY TOPICAL CORTICOSTEROID (E.G., TRIAMCINOLONE ACETONIDE, FLUOCINONIDE, CLOBETASOL PROPIONATE, HALOBETASOL PROPIONATE) OR ONE NON-STEROIDAL TOPICAL IMMUNOMODULATING AGENT (E.G., EUCRISA, OPZELURA, PIMECROLIMUS, TACROLIMUS). AS AND NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG) AND INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF BLOCKERS.CD AND UC: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED RENEWAL: RA, PSA, UC, AS, AD, GCA AND NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

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

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

URIDINE TRIACETATE

Affected Drugs:
Xuriden

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)

Age Restrictions:N/A

Prescription Order Restrictions:PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES

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

USTEKINUMAB

Affected Drugs:
Stelara
Steqeyma
Ustekinumab
Yesintek

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. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.

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

Other Criteria:INITIAL: PSA: FOR BIOLOGIC THERAPY-NAIVE PATIENTS 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. CD: NO ADDITIONAL MEDICAL INFORMATION IS REQUIRED. RENEWAL: PSA, PSO, CD, UC: CONTINUES TO BENEFIT FROM THE MEDICATION.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

VALBENAZINE

Affected Drugs:
Ingrezza

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: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

VANDETANIB

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

VEMURAFENIB

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

VENETOCLAX

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

VERICIGUAT

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: Yes

VIGABATRIN

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: Yes

VIMSELTINIB

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

VISMODEGIB

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

VORASIDENIB

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

VORICONAZOLE SUSPENSION

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: Yes

VYEPTI

Affected Drugs:
Vyepti

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Preventive treatment of migraine. 2) Document: a) 4 or more migraine days per month.

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Headache Specialist, 2) Internist, 3) Neurologist, or 4) Pain Specialist

Coverage Duration:12 months

Other Criteria:1) Validate if intravenous infusion drugs are covered under the Pharmacy benefit. Normally these drugs are not covered under the Pharmacy benefit, validate coverage.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

WINREVAIR

Affected Drugs:
Winrevair

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Pulmonary Arterial Hypertension, WHO Group 1, 2) Document (for first prescription): a) Cardiac Catheterization Results, b) Laboratories of hemoglobin and platelet count prior to first dose (results must have a date within 30 days prior to the request), AND c) Documentation patient has received or is currently receiving treatment with at least two drugs with different mechanisms of action for PAH (e.g. endothelin receptor antagonist, PDE-5 inhibitor, prostacyclin pathway agents).

Age Restrictions:18 years of age or older

Prescription Order Restrictions:1) Pulmonologist, 2) Cardiologist

Coverage Duration:12 months

Other Criteria:1) Treatment should not be initiated if platelet count is less than 50,000 platelets/mcL due to increased bleeding risk.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: Yes

XANOMELINE/TROSPIUM

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: Yes

ZANIDATAMAB HRII

Affected Drugs:
Ziihera

Off-Label Uses:N/A

Exclusion Criteria:PREGNANCY

Required Medical Information:1) DIAGNOSIS: FOR THE TREATMENT OF PREVIOUSLY TREATED, UNRESECTABLE OR METASTATIC HER2-POSITIVE (IHC 3+) BILIARY TRACT CANCER (BTC). 2) DOCUMENT: A) POSITIVE HER2 STATUS, B) DOCUMENTATION OF PRIOR AND/OR CURRENT FIRST-LINE (I.E. CHEMOTHERAPY-BASED REGIMEN) TREATMENTS PATIENT HAS USED FOR BTC AND C) PATIENTS ACTUAL BODY WEIGHT (WEIGHT-BASED DOSING).

Age Restrictions:18 YEARS OF AGE AND OLDER

Prescription Order Restrictions:PRESCRIBED BY OR IN CONSULTATION WITH 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

ZANUBRUTINIB

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

ZELSUVMI

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

ZENOCUTUZUMAB ZBCO

Affected Drugs:
Bizengri (750 MG Dose)

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: A) TREATMENT OF ADULTS WITH ADVANCED, UNRESECTABLE, OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) HARBORING A NEUREGULIN 1 (NRG1) GENE FUSION WITH DISEASE PROGRESSION ON OR AFTER PRIOR SYSTEMIC THERAPY, B) TREATMENT OF ADULTS WITH ADVANCED, UNRESECTABLE, OR METASTATIC PANCREATIC ADENOCARCINOMA HARBORING A NRG1 GENE FUSION WITH DISEASE PROGRESSION ON OR AFTER PRIOR SYSTEMIC THERAPY. 2) DOCUMENT FOR ALL INDICATIONS: A) PRESENCE OF NRG1 GENE FUSION AS DETERMINED BY AN FDA-APPROVED TEST, B) DISEASE PROGRESSION ON OR AFTER PRIOR SYSTEMIC THERAPY

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:1) FDA APPROVED TEST TO DETERMINE PRESENCE OF NRG1 GENE FUSION DETECTED BY DNA-BASED NEXT-GENERATION SEQUENCING (NGS) OR BY RNA-BASED NGS THAT MAY INCLUDE DNA SEQUENCING.

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

ZIFTOMENIB

Affected Drugs:
Komzifti

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) Diagnosis: Relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation. 2) Document: a) Susceptible nucleophosmin 1 (NPM1) mutation, b) Prescriber attestation patient has no alternative treatment options.

Age Restrictions:18 years 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

ZOLBETUXIMAB CLZB

Affected Drugs:
Vyloy

Off-Label Uses:N/A

Exclusion Criteria:N/A

Required Medical Information:1) DIAGNOSIS: LOCALLY ADVANCED UNRESECTABLE OR METASTATIC HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA WHOSE TUMORS ARE CLAUDIN (CLDN) 18.2 POSITIVE. 2) DOCUMENTATION OF A) USE IN COMBINATION WITH FLUOROPYRIMIDINE AND PLATINUM-CONTAINING CHEMOTHERAPY. B) EVIDENCE OR PRESENCE OF (HER2)-NEGATIVE OR CLAUDIN (CLDN) 18.2 POSITIVE AS DETERMINED BY AN FDA-APPROVED TEST.

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

ZURANOLONE

Affected Drugs:
Zurzuvae

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 IN CONSULTATION WITH A PSYCHIATRIST OR OBSTETRICIAN/GYNECOLOGIST

Coverage Duration:14 DAYS

Other Criteria:DIAGNOSIS OF POSTPARTUM DEPRESSION (PPD) 1) PHYSICIAN ATTESTATION OF MODERATE TO SEVERE PPD DIAGNOSIS 2) PATIENT IS LESS THAN OR EQUAL TO 12 MONTHS POSTPARTUM

PA Indications: All FDA-approved Indications.

Part B Prerequisite: No

Prerequisite Therapy Required: No

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

Drug Name	Drug Name
Acetylcysteine INH	Acyclovir Sodium IV
Akynzeo Oral Cap	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
Flebogamma DIF IV	Fluconazole in Sodium Chloride IV
Gammagard INJ	Gammagard ERC INJ
Gammagard S/D Less IgA IV	Gammaplex IV
Gamunex-C INJ	Gengraf Oral Cap
Granisetron HCl Oral Tab	Heplisav-B
Imovax Rabies IM	Intralipid IV
Ipratropium Bromide INH	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
PreHevbrio IM	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
Xatmep Oral Soln	

(*) Drug may be covered under Medicare Part 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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