# Prominence Health

## 2027

## Prior Authorization Criteria

## ABALOPARATIDE*

**Affected Drugs:**
Tymlos

* 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.

## 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:**
Adalimumab-aaty (1 Pen)
Adalimumab-aaty (2 Pen)
Adalimumab-aaty (2 Syringe)
Adalimumab-aaty CD/UC/HS Start
Humira-CD/UC/HS Starter
Humira-Ped<40kg Crohns Starter
Humira-Ped>/=40kg Crohns Start
Humira-Ped>/=40kg UC Starter
Yuflyma (1 Pen)
Yuflyma (2 Syringe)
Yuflyma-CD/UC/HS Starter

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

## 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

## ALIROCUMAB

**Affected Drugs:**
Praluent

**Off-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

* 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.

## APALUTAMIDE*

**Affected Drugs:**
Erleada

* 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.

## 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

* 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.

## 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

* 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.

## AVACOPAN*

**Affected Drugs:**
Tavneos

* 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.

## 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

* 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.

## 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

* 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.

## 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

* 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.

## BEMPEDOIC ACID-EZETIMIBE*

**Affected Drugs:**
Nexlizet

* 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.

## BENRALIZUMAB*

**Affected Drugs:**
Fasenra
Fasenra Pen

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

## BEROTRALSTAT*

**Affected Drugs:**
Orladeyo

* 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.

## 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
Bosutinib

**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

* 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.

## 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

* 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.

## 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 (10 Tabs)
Cladribine (4 Tabs)
Cladribine (5 Tabs)
Cladribine (6 Tabs)
Cladribine (7 Tabs)
Cladribine (8 Tabs)
Cladribine (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

## DALFAMPRIDINE*

**Affected Drugs:**
Dalfampridine ER

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

## 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

* 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.

## 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

* 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.

## 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

* 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.

## 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

* 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.

## DUPILUMAB*

**Affected Drugs:**
Dupixent

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

## 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

## EDARAVONE*

**Affected Drugs:**
Radicava ORS Starter Kit

* 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.

## 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

* 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.

## 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

* 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.

## 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:**
Eltrombopag Olamine
Promacta

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

## 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 ANTAGONIST - AMBRISENTAN*

**Affected Drugs:**
Ambrisentan

* 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.

## ENDOTHELIN RECEPTOR ANTAGONIST - BOSENTAN*

**Affected Drugs:**
Bosentan
Tracleer

* 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.

## ENDOTHELIN RECEPTOR ANTAGONIST - MACITENTAN*

**Affected Drugs:**
Macitentan
Opsumit

* 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.

## 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

## ENTYVIO SC*

**Affected Drugs:**
Entyvio Pen

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

## ENZALUTAMIDE*

**Affected Drugs:**
Xtandi

* 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.

## 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

* 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.

## 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

* 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.

## ETANERCEPT*

**Affected Drugs:**
Enbrel
Enbrel Mini
Enbrel SureClick

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

## EVEROLIMUS

**Affected Drugs:**
Everolimus
Yulithira

**Off-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

* 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.

## FEDRATINIB*

**Affected Drugs:**
Inrebic

* 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.

## FENFLURAMINE*

**Affected Drugs:**
Fintepla

* 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.

## 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

## FILSPARI*

**Affected Drugs:**
Filspari

* 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.

## 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)

* 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.

## 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

* 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.

## 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

* 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.

## GLP1 AGONIST - DULAGLUTIDE

**Affected Drugs:**
Trulicity

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**1) Chart notes showing diagnosis of type 2 diabetes mellitus OR confirmed diagnosis of Diabetes Mellitus Type 2 by accepted lab testing per treatment guidelines (e.g FPG, 2-h PG, GLU, random plasma glucose, or A1C).

**Age Restrictions:**N/A

**Prescription Order Restrictions:**N/A

**Coverage Duration:**12 Months

**Other Criteria:**Applicable Lab Values for diagnosis confirmation: A1C greater than or equal to 6.5%, Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL) during OGTT (oral glucose tolerance test)

**PA Indications:**All FDA-approved Indications.

**Part B Prerequisite:**No

**Prerequisite Therapy Required:**No

## GLP1 AGONIST - SEMAGLUTIDE

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

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**1) Chart notes showing diagnosis of type 2 diabetes mellitus OR confirmed diagnosis of Diabetes Mellitus Type 2 by accepted lab testing per treatment guidelines (e.g FPG, 2-h PG, GLU, random plasma glucose, or A1C).

**Age Restrictions:**N/A

**Prescription Order Restrictions:**N/A

**Coverage Duration:**12 Months

**Other Criteria:**Applicable Lab Values for diagnosis confirmation: A1C greater than or equal to 6.5%, Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL) during OGTT (oral glucose tolerance test)

**PA Indications:**All FDA-approved Indications.

**Part B Prerequisite:**No

**Prerequisite Therapy Required:**No

## GLP1 AGONIST - TIRZEPATIDE

**Affected Drugs:**
Mounjaro

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**1) Chart notes showing diagnosis of type 2 diabetes mellitus OR confirmed diagnosis of Diabetes Mellitus Type 2 by accepted lab testing per treatment guidelines (e.g FPG, 2-h PG, GLU, random plasma glucose, or A1C).

**Age Restrictions:**N/A

**Prescription Order Restrictions:**N/A

**Coverage Duration:**12 Months

**Other Criteria:**Applicable Lab Values for diagnosis confirmation: A1C greater than or equal to 6.5%, Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL) during OGTT (oral glucose tolerance test)

**PA Indications:**All FDA-approved Indications.

**Part B Prerequisite:**No

**Prerequisite Therapy Required:**No

## GLYCEROL PHENYLBUTYRATE

**Affected Drugs:**
Glycerol Phenylbutyrate

**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

* 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.

## 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 - BENZTROPINE*

**Affected Drugs:**
Benztropine Mesylate

* 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.

## HIGH RISK - CYCLOBENZAPRINE*

**Affected Drugs:**
Cyclobenzaprine HCl

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

## HIGH RISK - CYPROHEPTADINE*

**Affected Drugs:**
Cyproheptadine HCl

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

## HIGH RISK - DICYCLOMINE

**Affected Drugs:**
Dicyclomine 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:**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 - DIPHENOXYLATE-ATROPINE

**Affected Drugs:**
Diphenoxylate-Atropine

**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

## HIGH RISK - DISOPYRAMIDE*

**Affected Drugs:**
Disopyramide Phosphate

* 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.

## HIGH RISK - HYDROXYZINE*

**Affected Drugs:**
hydrOXYzine HCl

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

## HIGH RISK - PROMETHAZINE

**Affected Drugs:**
Promethazine 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

## HIGH RISK - SCOPALAMINE

**Affected Drugs:**
Scopolamine

**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:**PROVIDER ATTESTATION OF RISKS AND BENEFITS OF THERAPY IS REQUIRED.

**PA Indications:**All FDA-approved Indications.

**Part B Prerequisite:**No

**Prerequisite Therapy Required:**Yes

**Affected Drugs:**
PARoxetine HCl

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

## IBERDOMIDE*

**Affected Drugs:**
Zenbexus

* 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.

## 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

## 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

* 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.

## 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 BETA 1A (AVONEX)

**Affected Drugs:**
Avonex Pen
Avonex Prefilled

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**Diagnosis of Multiple Sclerosis

**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

## INTERFERON BETA 1B (BETASERON)

**Affected Drugs:**
Betaseron

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**Diagnosis of Multiple Sclerosis

**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

## 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

## IVACAFTOR*

**Affected Drugs:**
Kalydeco

* 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.

## 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

* 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.

## LANADELUMAB*

**Affected Drugs:**
Takhzyro

* 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.

## 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

## LEBRIKIZUMAB-LBKZ*

**Affected Drugs:**
Ebglyss

* 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.

## LECANEMAB*

**Affected Drugs:**
Leqembi Iqlik
Leqembi Iqlik (500 MG Dose)

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

## LEDIPASVIR-SOFOSBUVIR*

**Affected Drugs:**
Ledipasvir-Sofosbuvir

* 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.

## 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

* 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.

## LEVODOPA*

**Affected Drugs:**
Inbrija

* 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.

## LIDOCAINE

**Affected Drugs:**
Lidocaine
Lidocaine HCl
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

* 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.

## LOMITAPIDE*

**Affected Drugs:**
Juxtapid

* 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.

## LOMUSTINE

**Affected Drugs:**
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

* 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.

## LUMACAFTOR-IVACAFTOR*

**Affected Drugs:**
Orkambi

* 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.

## 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

* 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.

## 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

* 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.

## 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

## MIRDAMETINIB*

**Affected Drugs:**
Gomekli

* 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.

## 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

## NEMOLIZUMAB-ILTO*

**Affected Drugs:**
Nemluvio

* 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.

## 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

**Off-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

* 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.

## 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

## 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

* 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.

## 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

* 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.

## 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

* 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.

## 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

## 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

## PEGINTERFERON BETA 1A (PLEGRIDY)

**Affected Drugs:**
Plegridy

**Off-Label Uses:**N/A

**Exclusion Criteria:**N/A

**Required Medical Information:**Diagnosis of Multiple Sclerosis

**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

## 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

* 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.

## 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

* 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.

## PIRFENIDONE*

**Affected Drugs:**
Pirfenidone

* 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.

## 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:**
Posaconazole

* 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.

## 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

## 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

## RELACORILANT*

**Affected Drugs:**
Lifyorli (125 MG DOSE)
Lifyorli (150 MG DOSE)

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

## 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)

* 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.

## 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

* 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.

## RIOCIGUAT*

**Affected Drugs:**
Adempas

* 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.

## 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

* 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.

## RISDIPLAM*

**Affected Drugs:**
Evrysdi

* 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.

## 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
Besremi Pen

**Off-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
Jakafi XR

* 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.

## SECUKINUMAB*

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

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

## SELEXIPAG*

**Affected Drugs:**
Uptravi
Uptravi Titration

* 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.

## 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

## SEMAGLUTIDE*

**Affected Drugs:**
Wegovy

* 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.

## SEVABERTINIB*

**Affected Drugs:**
Hyrnuo

* 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.

## SILDENAFIL FOR PAH*

**Affected Drugs:**
Sildenafil Citrate

* 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.

## SIPONIMOD*

**Affected Drugs:**
Mayzent
Mayzent Starter Pack

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

## 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

* 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.

## SOFOSBUVIR/VELPATASVIR*

**Affected Drugs:**
Sofosbuvir-Velpatasvir

* 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.

## SOLRIAMFETOL*

**Affected Drugs:**
Sunosi

* 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.

## SOMATROPIN - NORDITROPIN*

**Affected Drugs:**
Norditropin FlexPro

* 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.

## SOMATROPIN - SEROSTIM*

**Affected Drugs:**
Serostim

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

## 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

* 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.

## 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:**
Envarsus XR
Tacrolimus ER

**Off-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

## TADALAFIL FOR PAH*

**Affected Drugs:**
Alyq
Tadalafil (PAH)

* 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.

## TAFAMIDIS

**Affected Drugs:**
Vyndamax

**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

* 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.

## TARPEYO*

**Affected Drugs:**
Tarpeyo

* 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.

## 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

## 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

* 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.

## 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

## TIOPRONIN*

**Affected Drugs:**
Tiopronin

* 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.

## 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:**
Tofacitinib Citrate
Tofacitinib Citrate ER

**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:**
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

* 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.

## 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

## TREPROSTINIL*

**Affected Drugs:**
Yutrepia

* 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.

## 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

* 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.

## UBROGEPANT*

**Affected Drugs:**
Ubrelvy

* 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.

## 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

* 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.

## 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

* 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.

## 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

## VELSIPITY*

**Affected Drugs:**
Velsipity

* 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.

## 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

* 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.

## VIGABATRIN

**Affected Drugs:**
Vigabatrin
Vigadrone
Vigafyde

**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

## VOSEVI*

**Affected Drugs:**
Vosevi

* 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.

## 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

* 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.

## 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

## ZIDESAMTINIB*

**Affected Drugs:**
Jideytro

* 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.

## 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

* 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.

## ZYMFENTRA*

**Affected Drugs:**
Zymfentra (2 Pen)
Zymfentra (2 Syringe)

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

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

| 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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