ABILIFY MYCITE

Products Affected

- Abilify Mycite

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to formulary generic oral aripiprazole.

ACTHAR

Products Affected

- Acthar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in members with multiple sclerosis (MS) as pulse therapy on a monthly basis.
Required Medical Information	Covered for the following indications: 1. West syndrome (Infantile Spasms) 2. Acute exacerbations of multiple sclerosis (MS) for members receiving concurrent immunomodulator therapy (such as interferon beta 1a, glatiramer acetate, dimethyl fumerate, fingolimod, teriflunomide) 3. Rheumatic disorders 4. Collagen diseases 5. Dermatologic diseases 6. Allergic states 7. Ophthalmic diseases 8. Respiratory diseases 9. Transfusion reaction due to serum protein reaction 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (such as cortisone or dexamethasone), calcineurin inhibitors (such as cyclosporine or tacrolimus). 11. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. 12. Gout and intolerance or contraindication to at least two first-line gout therapies (such as allopurinol, probenecid, colchicine). 13. Pediatric acquired epileptic aphasia. For covered indications 3 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (such as IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	N/A
Prescriber Restrictions	Infantile spasm: Neurologist, Acute exacerbation of MS: Neurologist or MS specialist
Coverage Duration	Acute exacerbation of MS: 3 weeks, Infantile spasms: 4 weeks, All other indications: 6 months
Other Criteria	Acute exacerbation of MS: Member must have tried and failed, or has a contraindication or intolerance to high-dose glucocorticoids (e.g. IV methylprednisolone 1000 mg daily for three to five days).

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADAGEN

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), osteosarcoma.
Exclusion Criteria	N/A
Required Medical Information	For breast cancer: 1) The patient has recurrent or metastatic hormone receptor positive, HER2 negative disease, 2) Afinitor will be used in combination with exemestane, and 3) The patient's disease either a) has progressed while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior antigiogenic therapy (e.g., sunitinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year
Other Criteria	For prevention of migraines: Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary alternatives: atenolol, candesartan, divalproex sodium delayed release, divalproex sodium extended release, lisinopril, metoprolol succinate, metoprolol tartrate, nadolol, propranolol immediate release, propranolol extended release, timolol, topiramate immediate release, topiramate extended release, venlafaxine extended release.

AJOVY

Products Affected

- Ajovy

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year
Other Criteria	For prevention of migraines: Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary alternatives: atenolol, candesartan, divalproex sodium delayed release, divalproex sodium extended release, lisinopril, metoprolol succinate, metoprolol tartrate, nadolol, propranolol immediate release, propranolol extended release, timolol, topiramate immediate release, topiramate extended release, venlafaxine extended release.

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. Patients with Scheie syndrome must have moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALIQOPA

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ALPHA1-PROTEINASE INHIBITOR

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry). Patients must have a pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AMPYRA

Products Affected

- Ampyra
- Dalfampridine Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ANABOLIC STEROIDS

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ANADROL

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ANALGESICS-AGE EDIT

Products Affected

- Demerol INJ
- Demerol TABS 100MG
- Indocin SUPP
- Indocin SUSP
- Indomethacin CAPS
- Indomethacin Er
- Ketorolac Tromethamine INJ 15MG/ML, 30MG/ML
- Ketorolac Tromethamine TABS
- Meperidine Hcl INJ 100MG/ML, 10MG/ML, 25MG/ML, 50MG/ML
- Meperidine Hcl ORAL SOLN
- Meperidine Hcl TABS
- Pentazocine/naloxone Hcl
- Tivorbex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For acute gout: Member must have tried and failed, or has a contraindication or intolerance to two of the following covered formulary drugs: generic colchicine, Colcrys (colchicine), celecoxib, diclofenac, naproxen, piroxicam, or sulindac.

ANTIDEPRESSANTS-AGE EDIT

Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 10MG, 50MG
- Anafranil
- Chlordiazepoxide/amitriptyline
- Clomipramine Hcl CAPS
- Doxepin Hcl CAPS 100MG, 10MG, 150MG, 50MG, 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 25MG
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Perphenazine/amitriptyline
- Surmontil
- Tofranil TABS
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two formulary Selective serotonin reuptake inhibitors (SSRI), Serotonin–norepinephrine reuptake inhibitors (SNRI), or trazodone. If using target medication for a medically-accepted indication not shared by the required alternatives listed, then no trial of alternatives is required for that target high-risk medication. Applies to new starts only.

ANTIEMETICS-AGE EDIT

Products Affected

- Tigan CAPS 300MG
- Tigan INJ
- Trimethobenzamide Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to ondansetron or granisetron. If using target medication for a medically-accepted indication not shared by the required alternatives listed, then no trial of alternatives is required for that target high-risk medication.

ANTIHISTAMINES-AGE EDIT

Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Clemastine Fumarate TABS 2.68MG
- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS
- Cyproheptadine Hydrochloride SYRP
- Dexchlorpheniramine Maleate SOLN
- Diphenhydramine Hcl ELIX
- Diphenhydramine Hcl INJ 50MG/ML
- Karbinal Er
- Phenadoz
- Phenergan INJ
- Phenergan SUPP
- Promethazine Hcl INJ
- Promethazine Hcl SUPP
- Promethazine Hcl SYRP
- Promethazine Hcl TABS 12.5MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 25MG, 50MG
- Promethazine Vc Plain SOLN
- Promethazine/phenylephrine
- Promethegan
- Ryclora
- Ryvent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Perennial Allergic Rhinitis or Chronic Idiopathic Urticaria: Member must have tried and failed, or has a contraindication or intolerance to levocetirizine.

ANTIPARKINSON AGENTS-AGE EDIT

Products Affected

- Benztropine Mesylate INJ
- Benztropine Mesylate TABS
- Cogentin INJ
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Parkinson's disease: Member must have tried and failed, or has a contraindication or intolerance to one of the following: amantadine, pramipexole, or ropinirole.

ANXIOLYTICS-AGE EDIT

Products Affected

- Meprobamate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two of the following: buspirone, SSRIs, SNRIs

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARANESP

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For initiation of therapy: adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months (Note: for persons with iron deficiency, erythropoietin analog therapy may be initiated simultaneous with iron replacement), and the following criteria is met: hemoglobin (Hgb) is approaching or has fallen below 10 g/dl (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) or hematocrit of 30% OR patient will be starting myelosuppressive therapy and will have an anticipated hemoglobin drop associated with their therapy. For continuation of therapy: documentation of the below: for persons with anemia due to myelosuppressive anticancer chemotherapy: Hgb target of 12 g/dl For persons with chronic renal failure and end-stage renal disease (ESRD): Hgb target 10-11 g/dl. Continued use of the therapy is not covered if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3%) compared to pretreatment baseline by 12 weeks of treatment and whose hemoglobin level remains less than 10 g/dL (or the hematocrit is less than 30%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks

Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Procrit (erythropoietin injection). Excluded from members with Hgb at or above 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	N/A
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., oral allopurinol or febuxostat) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy (i.e., oral allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., oral allopurinol or febuxostat) (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	N/A

ARESTIN

Products Affected

- Arestin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dental professional
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

ARZERRA

Products Affected

- Arzerra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AVYCAZ

Products Affected

- Avycaz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Complicated intra-abdominal infections (cIAI): used in combination with metronidazole.

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BARBITURATES-AGE EDIT

Products Affected

- Butisol Sodium TABS 30MG
- Nembutal Sodium
- Pentobarbital Sodium INJ
- Seconal Sodium

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BAVENCIO

Products Affected

- Bavencio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

BAXDELA

Products Affected

- Baxdela

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease Specialist, or the prescriber has obtained a consult with an infectious disease specialist
Coverage Duration	14 days
Other Criteria	N/A

BELBUCA

Products Affected

- Belbuca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Acute or severe bronchial asthma. Known or suspected gastrointestinal obstruction, including paralytic ileus. Use for opioid dependence. Used as-needed (prn) analgesic.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Will not be used in combination with other long-acting opioid therapy. Alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain (i.e. non-opioid analgesics or immediate-release opioids).

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	Patient has been diagnosed with active, autoantibody-positive systemic lupus erythematosus (SLE). Patient is currently receiving standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BENZNIDAZOLE

Products Affected

- Benznidazole

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in members who have taken disulfiram within the last two weeks.
Required Medical Information	Chagas Disease: patient has serologic evidence of T. cruzi infection.
Age Restrictions	Covered for members between ages of 2 and 12 years old.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BESPONSA

Products Affected

- Besponsa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BEVACIZUMAB

Products Affected

- Mvasi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BEVYXXA

Products Affected

- Bevyxxa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Active pathological bleeding.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	42 days
Other Criteria	N/A

BEXAROTENE

Products Affected

- Bexarotene
- Targretin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BLINCYTO

Products Affected

- Blincyto

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only. Drug is also subject to a Part B versus Part D coverage determination.

BOSENTAN

Products Affected

- Bosentan
- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed/refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) Patient has chronic phase CML, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient received a hematopoietic stem cell transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic Use
Required Medical Information	Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency or urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS): Member must have tried and failed, or has a contraindication or intolerance to oxybutynin. Prophylaxis of headaches in adult patients with chronic migraine (15 days or more per month with headache lasting 4 hours a day or longer): Member must have tried and failed, or has a contraindication or intolerance to two preventative/prophylactic oral agents.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

BRAFTOVI

Products Affected

- Braftovi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BRAND TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- Abstral
- Actiq
- Lazanda
- Subsys

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant members. The member must not have any of the following contraindications: members with pain not associated with cancer OR that are opioid naïve.
Required Medical Information	For the management of breakthrough cancer pain in members with malignancies already receiving and tolerant to opioid therapy for their underlying cancer pain. Members considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	Covered for members 16 years of age and older.
Prescriber Restrictions	Oncologists and pain specialists who are experienced in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	Through end of plan contract year.
Other Criteria	Diagnosis of breakthrough cancer pain in opioid-tolerant members AND concomitant use of long acting opioid therapy, such as ONE of the following: controlled-release morphine or extended-release morphine or controlled-release oxycodone or fentanyl transdermal. Member must have tried and failed, or has a contraindication or intolerance to oral generic transmucosal fentanyl citrate and a short acting opiate, such as oxycodone, oxycodone/APAP, hydrocodone/APAP, hydromorphone, morphine sulfate, tramadol

BRISDELLE

Products Affected

- Brisdelle
- Paroxetine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BROVANA

Products Affected

- Brovana

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two of the following: Symbicort (budesonide/formoterol), Advair Diskus (fluticasone/salmeterol), Breo Ellipta (fluticasone/vilanterol), Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium bromide/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone furoate/umeclidinium bromide/vilanterol trifenatate). Drug is also subject to a Part B versus Part D coverage determination.

BUPHENYL

Products Affected

- Buphenyl POWD
- Sodium Phenylbutyrate POWD 3GM/TSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated for acute hyperammonemia emergency management.
Required Medical Information	Urea Cycle Disorders (UCD): Confirmed by enzymatic, biochemical or genetic testing. Will be used for chronic management of UCD.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BUPRENORPHINE

Products Affected

- Buprenorphine Hcl SUBL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant or breastfeeding and being prescribed the requested drug for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If the requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If the requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Induction 3 months, Maintenance Plan Year, Pregnancy/Breastfeeding Plan Year
Other Criteria	N/A

BUTALBITAL-AGE EDIT

Products Affected

- Allzital
- Ascomp/codeine
- Bupap TABS 300MG; 50MG
- Butalbital/acetaminophen
- Butalbital/acetaminophen/caffeine CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine
- Butalbital/aspirin/caffeine/codeine
- Esgic
- Fioricet CAPS
- Fiorinal CAPS
- Fiorinal/codeine #3
- Phrenilin Forte CAPS 300MG; 50MG; 40MG
- Tencon TABS 325MG; 50MG
- Vanatol Lq
- Vanatol S
- Zebutal CAPS 325MG; 50MG; 40MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For tension headache: Patient has a documented trial and failure of or intolerance or contraindication to rizatriptan and ibuprofen.

BUTRANS

Products Affected

- Buprenorphine PTWK
- Butrans

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression, Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, Known or suspected gastrointestinal obstruction, including paralytic ileus. As an as-needed (prn) analgesic.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CABLIVI

Products Affected

- Cablivi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial treatment: Patient has a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP), which includes thrombocytopenia and microscopic evidence of red blood cell fragmentation (e.g., schistocytes). For continuation of treatment: Confirmation that 1) Patient has received Cablivi in combination with plasma exchange and immunosuppressive therapy during plasma exchange and for 30 days beyond the last plasma exchange AND 2) patient has sign(s) of persistent underlying disease such as suppressed ADAMTS13 activity levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For initial treatment: 3 months For continuation: approval duration of 28 days
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CALCIPOTRIENE

Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN
- Calcipotriene/betamethasone Dipropionate
- Calcitrene
- Dovonex CREA
- Sorilux
- Taclonex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with demonstrated hypercalcemia or evidence of vitamin D toxicity.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAMBIA

Products Affected

- Cambia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to 2 of the following: ibuprofen, formulary generic triptan drugs (such as sumatriptan, eletriptan, naratriptan, rizatriptan)

CAMPATH

Products Affected

- Campath INJ 30MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): the requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CARAC

Products Affected

- Carac
- Fluorouracil CREA 0.5%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are pregnant or may become pregnant. Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CARDIOVASCULAR-AGE EDIT

Products Affected

- Dipyridamole TABS
- Disopyramide Phosphate CAPS
- Guanfacine Hcl
- Methyldopa TABS 250MG, 500MG
- Methyldopa/hydrochlorothiazide
- Nifedipine CAPS
- Norpace
- Procardia CAPS 10MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CEQUA

Products Affected

- Cequa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Ophthalmologist or Optometrist or Rheumatologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Dry eye disease (DED): Member must have tried and failed, or has a contraindication or intolerance to Restasis (cyclosporine emulsion).

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CHANTIX

Products Affected

- Chantix TABS 0.5MG, 1MG
- Chantix Continuing Month Pak
- Chantix Starting Month Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in the presence of known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis, a gallbladder confirmed as nonvisualizing after two consecutive single doses of dye, radiopaque stones, or gallstone complications or compelling reasons for gallbladder surgery including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary gastrointestinal fistula. Contraindicated in women who are or may become pregnant. Cumulative use longer than 24 months.
Required Medical Information	Documentation of start date of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years from initiation of therapy
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to ursodiol.

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For adjunctive treatment of peroxisomal disorders: The member must have signs and symptoms of liver disease (e.g. jaundice, hepatomegaly, dark urine, discolored stools), steatorrhea or complications from decreased fat soluble vitamin absorption. Renewal: Member must have had an improvement in liver function since the start of treatment.
Age Restrictions	N/A
Prescriber Restrictions	Hepatologist or Gastroenterologist
Coverage Duration	Initial approval: 3 months. Renewal: Through end of plan contract year.
Other Criteria	N/A

CHORIONIC GONADOTROPIN

Products Affected

- Chorionic Gonadotropin INJ
- Novarel
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and low luteinzing hormone (LH) (below normal reference value provided by the physician's laboratory) or follicle-stimulating hormone (FSH) (below normal reference value provided by the physician's laboratory). Hypogonadotropic Hypogonadism (Renewal): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. Hypogonadotropic Hypogonadism: Through end of plan contract year
Other Criteria	N/A

CINQAIR

Products Affected

- Cinqair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Diagnosis of Eosinophilic Phenotype Severe Asthma: Member has symptoms of severe, uncontrolled asthma that requires or remains uncontrolled despite treatment with high dose inhaled corticosteroids (ICS) plus a second controller and/or systemic corticosteroids (CS). Severe asthma defined by meeting one of these criteria: (1.) Poor symptom control: ACQ consistently greater than 1.5 or ACT less than 20, (2.) Frequent severe exacerbations: 2 or more bursts of systemic corticosteroids (greater than 3 days each) in previous year, (3.) Serious exacerbations: at least one hospitalization, ICU stay or mechanical ventilation in previous year, (4.) Airflow limitation: FEV1 less than 80% predicted following withholding of both SABA and LABA. (5.) Asthma worsens on tapering of corticosteroids. Documentation of eosinophilic phenotype determined by blood eosinophils greater than or equal to 400 cells/µL. For Renewals: Member has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath OR experienced a decrease in administration of rescue medication OR experienced a decrease in exacerbation frequency (no increase in ICS dose or CS dose) OR experienced an increase in predicted FEV1 from the pretreatment baseline OR has utilized the medication for greater than 24 months and has remained stable.
Age Restrictions	Covered for members aged 18 and older
Prescriber Restrictions	Allergist or immunologist or pulmonologist
Coverage Duration	Initial Approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (eg, levocetirizine) for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COLY-MYCIN

Products Affected

- Colistimethate Sodium INJ
- Coly-mycin M

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Administration via nebulizer.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year.
Other Criteria	Allow intravenous (IV) or intramuscularly (IM) use only. CMS endorsed compendia do not support inhalation/nebulization of colistimethate.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): The requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindications per FDA labeling.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

CRYSVITA

Products Affected

- Crysvita

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial treatment: 1) Confirmation that member will not be taking Crysvita with an oral phosphate or active vitamin D analogs AND 2) Confirmation that baseline fasting serum phosphorus level is below the reference range for patient age. For continuation of treatment: confirm improvement in phosphorus concentration
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For initial treatment: 4 months For continuation: Benefit year
Other Criteria	N/A

CYCLOSET

Products Affected

- Cycloset

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with syncopal migraine. Women who are nursing.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to metformin or metformin combination product.

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAKLINZA

Products Affected

- Daklinza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

DARZALEX

Products Affected

- Darzalex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

DEFERASIROX

Products Affected

- Deferasirox
- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DEMSER

Products Affected

- Demser

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DIABETES-AGE EDIT

Products Affected

- Chlorpropamide TABS
- Glucovance TABS 2.5MG; 500MG, 5MG; 500MG
- Glyburide TABS 1.25MG, 2.5MG, 5MG
- Glyburide Micronized
- Glyburide/metformin Hydrochloride
- Glynase

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Type 2 diabetes mellitus: Member must have tried and failed, or has a contraindication or intolerance to glipizide and glimepiride.

DIHYDROERGOT

Products Affected

- D.h.e. 45
- Dihydroergotamine Mesylate INJ
- Dihydroergotamine Mesylate SOLN
- Migranal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to dihydroergotamine or any component of the formulation, uncontrolled hypertension, ischemic heart disease, angina pectoris, history of MI, silent ischemia, coronary artery vasospasm including Prinzmetal angina, hemiplegic or basilar migraine, peripheral vascular disease, sepsis, severe hepatic or renal dysfunction, avoid use within 24 hours of 5-hydroxytryptamine-1 (5HT1) receptor agonists (triptans) or other serotonin agonists or ergot-like agents, concurrent use of peripheral and central vasoconstrictors, concurrent use of potent inhibitors of CYP3A4 (ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin, ketoconazole, itraconazole), pregnancy, breastfeeding.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DRIZALMA

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that the patient requires administration of the requested drug via nasogastric tube OR documentation that the patient is unable to swallow an intact capsule.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DRONABINOL

Products Affected

- Dronabinol
- Marinol
- Syndros

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV:6 months, PONV:1 month, Other medically accepted indications: Through end of plan contract year
Other Criteria	For chemotherapy-induced nausea and vomiting (CINV): The member is receiving cancer chemotherapy AND has failed one oral generic 5HT-3 receptor antagonist such as ondansetron or granisetron. There are no additional requirements for anorexia associated with weight loss in patients with AIDS. PONV = Postoperative nausea and vomiting. Drug is also subject to a Part B versus Part D coverage determination.

DUOBRII

Products Affected

- Duobrii

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Moderate-to-severe atopic dermatitis (AD): body surface area (BSA) involvement equal to or greater than 10 percent OR Eczema Area and Severity Index (EASI) score of 16 or greater OR affecting crucial body areas such as the hands, feet, face, or genitals. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	AD: Allergy/Immunology, Dermatologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	AD: Member must have tried and failed, or has a contraindication or intolerance to a generic formulary topical corticosteroid and generic topical tacrolimus.

DUZALLO

Products Affected

- Duzallo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe renal impairment (eCLcr less than 30 mL/min), end stage renal disease, kidney transplant recipients, or members on dialysis. Tumor lysis syndrome or Lesch-Nyhan syndrome
Required Medical Information	Documentation of estimated creatinine clearance greater than 30 mL/min. Hyperuricemia associated with gout: Member was unable to achieve a target serum uric acid level of less than 6mg/dL with a medically appropriate daily dose of allopurinol alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

DYSPORT

Products Affected

- Dysport
- Myobloc

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic Use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

EGRIFTA

Products Affected

- Egrifta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for weight loss management, members with active malignancy, members who are pregnant, or members with disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or head trauma.
Required Medical Information	HIV-infected patients with lipodystrophy: documentation of active antiretroviral therapy. Renewal: Documentation of clinical improvement (e.g., improvement in visceral adipose tissue (VAT), decrease in waist circumference, belly appearance) while on therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial and renewal: 6 months
Other Criteria	N/A

ELAPRASE

Products Affected

- Elaprase

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis II (Hunter syndrome, MPS II): The diagnosis of MPS II is confirmed by either an enzyme assay showing a deficiency of iduronate-2-sulfatase (I2S) enzyme activity or by genetic testing. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

ELELYSO

Products Affected

- Elelyso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Type 1 Gaucher disease: Diagnosis of Type 1 Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucosidase (glucocerebrosidase) enzyme activity or by genetic testing, and member has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly). Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

EMFLAZA

Products Affected

- Emflaza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement
Age Restrictions	N/A
Prescriber Restrictions	Duchenne muscular dystrophy (DMD): Prescribed by or in consultation with a physician who specializes in the treatment of DMD and/or neuromuscular disorders.
Coverage Duration	Initial: 6 months, Renewal: through end of plan contract year
Other Criteria	DMD: Member must have tried and failed, or have a contraindication or intolerance to prednisone.

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year
Other Criteria	For prevention of migraines: Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary alternatives: atenolol, candesartan, divalproex sodium delayed release, divalproex sodium extended release, lisinopril, metoprolol succinate, metoprolol tartrate, nadolol, propranolol immediate release, propranolol extended release, timolol, topiramate immediate release, topiramate extended release, venlafaxine extended release.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	5 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENTYVIO

Products Affected

- Entyvio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist or Gastroenterologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Crohn's Disease (CD): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab) or Remicade (infliximab). Ulcerative Colitis (UC): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab), Remicade (infliximab), or Xeljanz (tofacitinib).

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EPO

Products Affected

- Procrit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery and 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 weeks

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For anemia in CKD, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.

EPOGEN

Products Affected

- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Retacrit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension. Pure red cell aplasia (PRCA) that begins after treatment with erythropoietin protein drugs.
Required Medical Information	For initiation of therapy: adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months (Note: for members with iron deficiency, erythropoietin analog therapy may be initiated simultaneous with iron replacement), and the following criteria is met: hemoglobin (Hgb) is approaching or has fallen below 10 g/dl or hematocrit of 30 percent or less OR for members who are undergoing elective, noncardiac, nonvascular surgery, perioperative hemoglobin is greater than 10 AND less than or equal to 13 g/dL OR member will be starting myelosuppressive therapy and will have an anticipated hemoglobin drop associated with their therapy. For continuation of therapy: For members with anemia due to myelosuppressive anticancer chemotherapy: Hgb target of 12 g/dl. For members with chronic renal failure and end-stage renal disease (ESRD): Hgb target 10-11 g/dl. For members with other indications (e.g., ZVD HIV therapy): Hgb target of 12 g/dl. For members undergoing high risk surgery: Hgb target of 13 g/dl. Continued use of the therapy is not covered if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3 percent) compared to pretreatment baseline by 8 weeks of treatment and whose hemoglobin level remains less than 10 g/dL (or the hematocrit is less than 30 percent).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Surgery: 4 weeks, All other indications: 12 weeks

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Member must have tried and failed, or has a contraindication or intolerance to Procrit (epoetin alfa).

ERAXIS

Products Affected

- Eraxis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 weeks
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to fluconazole and voriconazole.

ERBITUX

Products Affected

- Erbitux

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Ras-mutant colorectal cancer.
Required Medical Information	Metastatic Colorectal Cancer (mCRC): K-Ras testing has been performed.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only. Will not be used concomitantly with Avastin (bevacizumab), Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), or Vectibix (panitumumab).

ERGOLOID-AGE EDIT

Products Affected

- Ergoloid Mesylates TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For treatment of Alzheimer's/Dementia: Member must have tried and failed, or has a contraindication or intolerance to two of the following: galantamine, rivastigmine, or donepezil.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Non-metastatic, castration-resistant prostate cancer (NM-CRPC): member will be receiving a gonadotropin-releasing hormone (GnRH) analog concurrently or had a bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ERWINAZE

Products Affected

- Erwinaze

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Acute lymphoid leukemia (ALL): History of serious pancreatitis, serious thrombosis, or serious hemorrhagic events with prior L-asparaginase therapy.
Required Medical Information	Member has developed hypersensitivity to E. coli-derived asparaginase.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ESTROGEN-AGE EDIT

Products Affected

- Activella
- Alora
- Amabelz
- Angeliq
- Bijuva
- Climara
- Climara Pro
- Combipatch
- Dotti
- Duavee
- Estrace TABS
- Estradiol ORAL TABS 0.5MG, 1MG, 2MG
- Estradiol PTTW
- Estradiol PTWK
- Estradiol/norethindrone Acetate
- Estropipate TABS
- Femhrt Low Dose
- Fyavolv
- Jevantique Lo
- Jinteli
- Lopreeza
- Menest TABS 0.3MG, 0.625MG, 1.25MG
- Menostar
- Mimvey
- Mimvey Lo
- Minivelle
- Norethindrone Acetate/ethinyl Estradiol TABS 2.5MCG; 0.5MG, 5MCG; 1MG
- Prefest
- Premarin INJ
- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- Premphase
- Prempro
- Vivelle-dot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.

Other Criteria	N/A

EVEKEO - AGE EDIT

Products Affected

- Amphetamine Sulfate
- Evekeo
- Evekeo Odt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for the diagnosis of Exogenous Obesity.
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EVENITY

Products Affected

- Evenity

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal women at high risk for fracture with documentation of the following: 1) Bone mineral density (BMD) T-score less than or equal to -2.5 at the total hip or femoral neck AND either one moderate or severe vertebral fracture or two mild vertebral fractures OR 2) Bone mineral density (BMD) T-score less than or equal to -2.0 at the total hip or femoral neck AND either two moderate or severe vertebral fractures or a history of a proximal femur fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months (lifetime)
Other Criteria	Postmenopausal Women with Osteoporosis at High Risk for Fracture: Member must have tried and failed, or has a contraindication or intolerance to Forteo (teriparatide) AND Prolia (denosumab injection).

EVZIO

Products Affected

- Evzio INJ 2MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EXJADE

Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Jadenu (deferasirox).

EXONDYS

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EYLEA

Products Affected

- Eylea

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Ophthamologist or Optometrist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is an obligate female carrier with a first degree male relative diagnosed with Fabry disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FASENRA

Products Affected

- Fasenra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Diagnosis of Eosinophilic Phenotype Severe Asthma: Member has symptoms of severe, uncontrolled asthma that requires or remains uncontrolled despite treatment with high dose inhaled corticosteroids (ICS) plus a second controller and/or systemic corticosteroids (CS). Documentation of eosinophilic phenotype. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	Covered for members aged 12 and older.
Prescriber Restrictions	For indicated asthma diagnosis: Allergist or immunologist or pulmonologist
Coverage Duration	Initial/Renewal: Through end of plan contract year
Other Criteria	N/A

FENTANYL ORAL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. The patient must not have any of the following contraindications: patients with pain not associated with cancer OR that are opioid naïve.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	Covered for patients 16 years of age and older.
Prescriber Restrictions	Oncologists and pain specialists who are experienced in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	Through end of plan contract year.
Other Criteria	Diagnosis of breakthrough cancer pain in opioid-tolerant patients AND concomitant use of long acting opioid therapy, such as ONE of these: controlled-release morphine or extended-release morphine or controlled-release oxycodone or fentanyl transdermal. Member must have tried and failed, or has a contraindication or intolerance to a short acting opiate, such as oxycodone, oxycodone/APAP, hydrocodone/APAP, hydromorphone, morphine sulfate, tramadol.

FERRIPROX

Products Affected

- Ferriprox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FETZIMA

Products Affected

- Fetzima
- Fetzima Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FILGRASTIM

Products Affected

- Nivestym
- Zarxio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For the treatment of anemia in MDS patients must meet all of the following: 1) Patient has symptomatic anemia, 2) The requested G-CSF product will be used in combination with an Erythropoiesis-stimulating agent (ESA), 3) Patient has MDS with a low or intermediate-1 risk stratification, 4) The serum erythropoietin level is less than, or equal to, 500 mU/ml. For neutropenia in MDS: 1) Member is neutropenic, 2) Patient experiences recurrent or resistant infections.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr
- Icatibant Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

FIRMAGON

Products Affected

- Firmagon

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

FLECTOR

Products Affected

- Diclofenac Epolamine
- Flector

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. For treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two generic oral nonsteroidal anti-inflammatories (NSAIDs).

FLUOROURACIL

Products Affected

- Efudex CREA
- Fluorouracil CREA 5%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are pregnant or may become pregnant. Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Applies to new starts only. If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal osteoporosis in men: patient has a) a history of osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) osteopenia with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND Patient has a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia with a high pre-treatment FRAX fracture probability.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (lifetime)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

FULPHILA

Products Affected

- Fulphila

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	'For diagnosis of cancer and receiving myelosuppressive chemotherapy: documented trial of 8 weeks of Neupogen.

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Partial-onset seizures - 4 years of age or older. Primary generalized tonic-clonic seizures - 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy: Patient was dependent on parenteral support for at least 12 months. For continuation: Requirement for parenteral support has decreased from baseline while on teduglutide therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GAZYVA

Products Affected

- Gazyva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HBsAg and anti-HBc. If positive, a physician with expertise in managing hepatitis B has been consulted regarding monitoring and consideration for HBV antiviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

GILENYA

Products Affected

- Gilenya CAPS 0.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) patient has a known sensitizing epidermal growth factor receptor (EGFR) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLATIRAMER

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Exclusion Criteria	N/A
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLEEVEC

Products Affected

- Gleevec TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to generic imatinib. Applies to new Starts Only.

GLYXAMBI

Products Affected

- Glyxambi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe renal impairment, end-stage renal disease, or dialysis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to 2 of the following: sitagliptin (Januvia, Janumet or Janumet XR), linagliptin (Tradjenta or Jentadueto), dapagliflozin (Farxiga), empagliflozin (Jardiance), empagliflozin-metformin (Synjardy), empagliflozin-metformin extended release (Synjardy XR), dapagliflozin-metformin HCl extended-release (Xigduo XR).

GOPRELTO

Products Affected

- Cocaine Hydrochloride
- Goprelto

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), stem cell transplantation related indications, acute lymphocytic leukemia (ALL), acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick
- Norditropin Flexpro

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

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	This medication is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HALAVEN

Products Affected

- Halaven

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

HARVONI

Products Affected

- Harvoni TABS 90MG; 400MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria applied consistent with current AASLD-IDSA guidance.Reminder for 8wk option if appropriate.
Other Criteria	Harvoni will not be used with other drugs containing sofosbuvir, including Sovaldi.

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neoadjuvant treatment for HER2-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	N/A

HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy and continuation of Hetlioz therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder and 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and 3) unable to perceive light in both eyes. For patients currently on therapy with the requested medication, must meet at least one of the following: 1) increased total nighttime sleep or 2) decreased daytime nap duration.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	N/A

HIGH RISK MEDICATION

Products Affected

- Scopolamine
- Transderm-scop

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following: 1) Inadequate response, intolerance or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial at maximum recommended or tolerated dose OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate or cyclosporine b) Pharmacologic treatment with methotrexate or cyclosporine is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine), OR 2) Intolerance or contraindication to immunosuppressant therapy.

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HYDROXYPROGESTERONE CAPROATE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindications per FDA labeling.
Required Medical Information	Member is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Testing of Endogenous Estrogen Production: 2 months. All Others: Through end of plan contract year
Other Criteria	Applies to new starts only.

HYDROXYZINE-AGE EDIT

Products Affected

- Hydroxyzine Hcl INJ 25MG/ML
- Hydroxyzine Hcl SYRP
- Hydroxyzine Hcl TABS 25MG
- Hydroxyzine Hydrochloride INJ
- Hydroxyzine Hydrochloride TABS 10MG, 50MG
- Hydroxyzine Pamoate CAPS
- Vistaril CAPS 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus 1) A non-HRM alternative drug levocetirizine has not been tried. AND 2) The patient has a contraindication to a non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) A non-HRM alternative drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, well-differentiated/dedifferentiated liposarcoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma.
Exclusion Criteria	N/A
Required Medical Information	For mantle cell lymphoma: 1) the requested medication will be used in a patient who has received at least one prior therapy, OR 2) the requested medication will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested medication will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested medication will be used as a single agent for disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

IMPAVIDO

Products Affected

- Impavido

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy. Sjögren-Larsson-Syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

IMVEXXY

Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Undiagnosed abnormal genital bleeding, Known, suspected, or history of breast cancer, Known or suspected estrogen-dependent neoplasia, Active DVT, PE, or history of these conditions, Active arterial thromboembolic disease (for example, stroke and MI) or a history of these conditions, Known liver impairment or disease, Known protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INBRIJA

Products Affected

- Inbrija

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients currently taking a nonselective monoamine oxidase (MAO) inhibitor or who have recently (within 2 weeks) taken a nonselective MAO inhibitor
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Must meet all of the following prior to beginning therapy with the requested medication (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Doses greater than 5 mg/kg in members with moderate to severe heart failure (New York Heart Association [NYHA] Functional Class III/IV).
Required Medical Information	For chronic severe plaque psoriasis (PsO): Psoriasis Area and Severity Index (PASI) score of 10 or more and body surface area (BSA) involvement equal to or greater than 10% OR affecting crucial body areas such as the hands, feet, face, or genitals. For fistulizing Crohn's disease: Require diagnosis of fistulizing disease. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Rheumatologist or Dermatologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year

Other Criteria	For moderate to severe active Crohn's disease (CD): inadequate response to one corticosteroid such as prednisone, budesonide, methylprednisolone AND a trial and failure of Humira (adalimumab) or Remicade (infliximab). For chronic severe PsO: prior use of one of the following- cyclosporine or methotrexate or methoxsalen with UVA light (PUVA) AND a trial and failure of Humira (adalimumab) or Remicade (infliximab). For active psoriatic arthritis (PsA): prior use of one corticosteroid such as dexamethasone or methylprednisolone AND a trial and failure of Remicade (infliximab), Humira (adalimumab) or Xeljanz/XR (tofacitinib). For moderate to severe rheumatoid arthritis (RA): trial and failure of two of the following: Humira (adalimumab), Remicade (infliximab), Xeljanz/ XR (tofacitinib). For moderate to severe active ulcerative colitis (UC): inadequate response to one 5-aminosalicylic acid product (5-ASA) such as sulfasalazine, mesalamine, balsalazide, or one corticosteroid such as prednisone or methylprednisolone AND a trial and failure of Humira (adalimumab), Remicade (infliximab), or Xeljanz (tofacitinib). For ankylosing spondylitis (AS): Require documentation of inadequate response to maximum tolerated dose of (1) non-steroidal anti-inflammatory drug (NSAID) AND a trial and failure of Humira (adalimumab) or Remicade (infliximab).

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia (TD): Documentation of the member's current Abnormal Involuntary Movement Scale (AIMS) score. Renewal: Documentation that the member's TD symptoms have improved as indicated by a decreased AIMS score from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INSOMNIA AGENTS-AGE EDIT

Products Affected

- Ambien
- Ambien Cr
- Edluar
- Eszopiclone
- Intermezzo
- Lunesta
- Sonata
- Zaleplon
- Zolpidem Tartrate
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

INTRAROSA

Products Affected

- Intrarosa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Undiagnosed abnormal genital bleeding.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IR BEFORE ER

Products Affected

- Conzip
- Dolophine TABS
- Duragesic
- Embeda
- Exalgo
- Fentanyl
- Hydromorphone Hcl Er T24A 12MG, 16MG, 8MG
- Hydromorphone Hydrochloride Er
- Hysingla Er
- Kadian CP24 100MG, 10MG, 200MG, 20MG, 30MG, 40MG, 50MG, 60MG, 80MG
- Levorphanol Tartrate TABS
- Methadone Hcl CONC
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadose CONC 10MG/ML
- Methadose Sugar-free
- Morphabond Er
- Morphine Sulfate Er CP24
- Morphine Sulfate Er TBCR
- Ms Contin TBCR
- Nucynta Er
- Oxymorphone Hydrochloride Er
- Oxymorphone Hydrochlorideer
- Tramadol Hcl Er CP24 100MG, 200MG, 300MG
- Tramadol Hcl Er TB24
- Xtampza Er
- Zohydro Er C12A

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR 6) The patient has severe continuous pain and has received an immediate-release opioid for at least one week
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ITRACONAZOLE

Products Affected

- Itraconazole CAPS
- Itraconazole SOLN
- Sporanox CAPS
- Sporanox SOLN
- Sporanox Pulsepak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	N/A
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

IVIG

Products Affected

- Bivigam
- Carimune Nanofiltered INJ 12GM, 6GM
- Cutaquig
- Cuvitru
- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Hizentra
- Hyqvia
- Octagam
- Panzyga
- Privigen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, Stiff-person syndrome, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	N/A
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. PRCA is secondary to parvovirus B19 infection.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.

Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

IXEMPRA

Products Affected

- Ixempra Kit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Neutrophil count less than 1500 cells/mm3 or a platelet count less than 100,000 cells/mm3. In combination with capecitabine, is contraindicated in members with AST or ALT greater than 2.5 x upper limit of normal (ULN) or bilirubin greater than 1 x ULN.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis, polycythemia vera in patients with inadequate response or intolerance to interferon therapy (interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JETREA

Products Affected

- Jetrea SOLN 0.375MG/0.3ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Ophthamologist or Optometrist
Coverage Duration	60 days
Other Criteria	If injections are being done in both eyes, the second eye will be injected at least 7 days after the initial injection in order to monitor the post-injection course including the potential for decreased vision in the injected eye. Repeated administration in the same eye is not covered.

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Neutrophil counts of less than or equal to 1,500/mm3. Severe hepatic impairment (total bilirubin greater than 3 times the upper limit of normal (ULN)).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only. Will not be used concomitantly with Xtandi (enzalutamide) or Zytiga (abiraterone).

JUBLIA

Products Affected

- Jublia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of onychomycosis of the toenails due to Trichophyton rubrum and Trichophyton mentagrophytes has been confirmed by either a positive KOH stain OR positive PAS stain (para-aminosalicylic acid) OR positive fungal culture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks
Other Criteria	Member has had a documented failure of an adequate trial of six weeks of one systemic (oral) antifungal alternative such as terbinafine unless there is presence of hepatic dysfunction or increased risk for liver disease OR member is female and is pregnant or breastfeeding OR member is less than 12 years of age.

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin), covered formulary fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

JYNARQUE

Products Affected

- Jynarque

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of signs or symptoms of significant liver impairment or injury (does not include uncomplicated polycystic liver disease), Concomitant use of strong CYP 3A inhibitors is contraindicated, Uncorrected abnormal blood sodium concentrations, Unable to sense or respond to thirst, Hypovolemia, Hypersensitivity to tolvaptan or any of its components, Uncorrected urinary outflow obstruction, Anuria.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

KALBITOR

Products Affected

- Kalbitor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medication is being requested for the treatment of acute angioedema attacks. For hereditary angioedema (HAE), 1) Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels), 2) For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test and 3) For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug induced) and EITHER a) Patient tested positive for the F12 gene mutation OR b) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (eg, levocetirizine) for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Will not be used concomitantly with other approved treatments for acute HAE attacks.

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
Age Restrictions	6 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

KERYDIN

Products Affected

- Kerydin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of onychomycosis of the toenails due to Trichophyton rubrum and Trichophyton mentagrophytes has been confirmed by either a positive KOH stain OR positive PAS stain (para-aminosalicylic acid) OR positive fungal culture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks
Other Criteria	Member has had a documented failure of an adequate trial of six weeks of one systemic (oral) antifungal alternative such as terbinafine, unless there is presence of hepatic dysfunction or increased risk for liver disease OR member is female and is pregnant or breastfeeding OR member is less than 12 years of age.

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of high dose aspirin. Severe pulmonary disease. Hepatic insufficiency.
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 2 months. Renewal: Through end of plan contract year.
Other Criteria	N/A

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	RA: Rheumatologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	For rheumatoid arthritis (RA): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab) AND Xejlanz/Xeljanz XR (tofacitinib).

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, malignant pleural mesothelioma, Merkel cell carcinoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KHAPZORY

Products Affected

- Khapzory

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KRINTAFEL

Products Affected

- Krintafel

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	G6PD deficiency or unknown G6PD status
Required Medical Information	Documentation that member has been tested for glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

KRYSTEXXA

Products Affected

- Krystexxa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for members with Glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	A documented diagnosis of symptomatic gout AND At least 3 gout flares in the previous 18 months that were inadequately controlled by colchicine and non-steroidal anti-inflammatory drugs (i.e., ibuprofen, naproxen), or at least 1 gout tophus or gouty arthritis AND Failure to normalize serum uric acid to less than 6 mg/dL after 3 months of maximum medically appropriate dose of xanthine oxidase inhibitors (allopurinol or Uloric (febuxostat)) or xanthine oxidase inhibitors are contraindicated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

KUVAN

Products Affected

- Kuvan

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

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin), covered formulary fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

LARTRUVO

Products Affected

- Lartruvo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

LEDIPASVIR - SOFOSBUVIR

Products Affected

- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have tried and failed, or has a contraindication or intolerance to 2 of the following if appropriate based on current AASLD/IDSA guidance: Epclusa (brand only), Harvoni (brand only), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LETAIRIS

Products Affected

- Ambrisentan
- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia (FN), the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For neutropenia in myelodysplastic syndromes (MDS): Patient has neutropenia and experiences recurrent or resistant infections.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

LEUPROLIDE

Products Affected

- Eligard
- Leuprolide Acetate INJ
- Lupaneta Pack
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in pregnancy.
Required Medical Information	For central precocious puberty (CPP), patiensts not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) A pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For endometriosis retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, and 2) Patient will be receiving add-back therapy (eg, norethindrone). For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) medication will be used in the preoperative setting to facilitate surgery. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: medication will be used as a single agent AND disease is persistent or recurrent. For breast cancer, patient must be premenopausal with hormone receptor positive disease.
Age Restrictions	CPP: Less than 12 years old if female and less than 13 years old if male. Endometriosis, fibroids, breast cancer, stromal tumors, epithelial ovarian/fallopian tube/primary peritoneal cancer: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	N/A

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LIDODERM

Products Affected

- Lidocaine PTCH
- Lidoderm

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LUCEMYRA

Products Affected

- Lucemyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

LUCENTIS

Products Affected

- Lucentis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Ophthamologist or Optometrist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUMOXITI

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For HER2-negative, recurrent or metastatic breast cancer patient must meet both of the following criteria: 1) patient has a deleterious or suspected deleterious germline BRCA mutation, and 2) patient has received prior treatment with chemotherapy or endocrine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MAKENA

Products Affected

- Hydroxyprogesterone Caproate INJ 250MG/ML
- Makena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Preterm birth prophylaxis: Member is having a current singleton pregnancy and has a history of prior spontaneous preterm birth of a single pregnancy. Initiation of treatment will be between 16 weeks, 0 days and 20 weeks, 6 days of gestation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	37 weeks
Other Criteria	N/A

MARQIBO

Products Affected

- Marqibo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with demyelinating conditions including Charcot-Marie-Tooth syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

MEGESTROL-AGE EDIT

Products Affected

- Megace Es
- Megestrol Acetate SUSP
- Megestrol Acetate TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For melanoma, tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MEMANTINE

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN
- Memantine Hydrochloride Er
- Namenda TABS
- Namenda Titration Pak
- Namenda Xr
- Namenda Xr Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

MEPRON

Products Affected

- Atovaquone SUSP
- Mepron SUSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Mild-to-moderate Pneumocystis jiroveci pneumonia/Prevention of Pneumocystis jiroveci pneumonia: Member must have tried and failed, or has a contraindication or intolerance to sulfamethoxazole/trimethoprim (SMZ/TMP).

MEPSEVII

Products Affected

- Mepsevii

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

METFORMIN ER

Products Affected

- Fortamet
- Glumetza
- Metformin Hydrochloride Er TB24 1000MG, 500MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute or chronic metabolic acidosis, including diabetic ketoacidosis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to generic metformin extended release (generic for Glucophage XR).

MIACALCIN

Products Affected

- Miacalcin INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Hypercalcemia (injection only): Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary agents: generic zoledronic acid, pamidronate, etidronate, Prolia (denosumab), Sensipar (cinacalcet), Xgeva (denosumab). Paget's Disease (injection only): Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary agents: etidronate, pamidronate, risedronate. Postmenopausal Osteoporosis (injection and nasal spray): Member must have tried and failed, or has a contraindication or intolerance to two of the following formulary agents: generic zoledronic acid, calcitonin spray, alendronate, risedronate, Forteo (teriparatide), Prolia (denosumab), Xgeva (denosumab).

MODAFINIL

Products Affected

- Modafinil
- Provigil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of narcolepsy: Documented by multiple sleep latency test (MSLT) less than 10 minutes or other appropriate testing. For treatment of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) when the member meets the following criteria: (1) A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA and meets ICSD or DSM diagnostic criteria AND (2) that the daytime fatigue is significantly impacting, impairing, or compromising the member's ability to function normally. For shift work sleep disorder (SWSD): Require confirmed diagnosis and the member must have a job that requires them to frequently rotate shifts or work at night, and be unable to adjust to their schedule.
Age Restrictions	N/A
Prescriber Restrictions	Board certified as a sleep specialist, ear, nose and throat, neurologist or pulmonologist, or has obtained a consult from a board certified sleep specialist.
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MOTEGRITY

Products Affected

- Motegrity

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, severe inflammatory conditions of the intestinal tract such as Crohn's disease, ulcerative colitis, and toxic megacolon/megarectum.
Required Medical Information	N/A
Age Restrictions	Covered for members 18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Amitiza (lubiprostone) and Linzess (linaclotide).

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

MUSCLE RELAXANTS-AGE EDIT

Products Affected

- Amrix
- Carisoprodol TABS
- Carisoprodol/aspirin
- Carisoprodol/aspirin/codeine
- Chlorzoxazone TABS
- Cyclobenzaprine Hydrochloride TABS
- Cyclobenzaprine Hydrochloride Er
- Fexmid
- Lorzone
- Metaxall
- Metaxalone
- Methocarbamol INJ 1000MG/10ML
- Methocarbamol TABS
- Norgesic Forte
- Orphenadrine Citrate INJ 30MG/ML
- Orphenadrine Citrate Er
- Robaxin INJ 1000MG/10ML
- Robaxin TABS
- Robaxin-750
- Skelaxin TABS 800MG
- Soma

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Partial lipodystrophy. Liver disease, including nonalcoholic steatohepatitis (NASH). HIV-related lipodystrophy. Members with metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy. General obesity not associated with congenital leptin deficiency.
Required Medical Information	Congenital or acquired generalized lipodystrophy: A documented diagnosis of complications of leptin deficiency (serum leptin levels less than the 7th percentile of normal values reported by the 3rd National Health and Nutrition Examination survey (less than 7.0ng/mL in females and less than 3.0 ng/mL in males)) in members with congenital generalized or acquired generalized lipodystrophy with at least one of the following: Type 2 diabetes mellitus OR Hypertriglyceridemia as defined by fasting triglyceride concentrations greater than 300 mg/dL OR Hyperinsulinemia as defined by fasting serum insulin greater than 20 uU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

MYLOTARG

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute promyelocytic leukemia (APL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MYTESI

Products Affected

- Mytesi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of the following: History of diarrhea for one month or more AND diarrhea is documented to be persistent loose stools despite regular use of anti-diarrheal medication (ADM) (e.g., loperamide, diphenoxylate, or bismuth subsalicylate) or one or more watery bowel movements per day without regular ADM use AND negative gastrointestinal (GI) culture, or stool test for ALL of the following: bacteria or bacteria toxin or ova or parasites or viruses AND member assessment to rule out other GI diseases associated with diarrhea (e.g. ulcerative colitis, Crohn's disease, celiac sprue (gluten-enteropathy), chronic pancreatitis, malabsorption).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member is currently on/taking anti-retroviral therapy.

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected to recover from the hypoparathyroidism.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested medication is initiated within two years after completing adjuvant trastuzumab based therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NEULASTA

Products Affected

- Neulasta
- Neulasta Onpro Kit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	For diagnosis of cancer and receiving myelosuppressive chemotherapy: documented trial of 8 weeks of Neupogen.

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation-related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute myeloid leukemia, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, osteosarcoma, chordoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: the patient has relapsed, metastatic, or unresectable disease. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with lenalidomide and dexamethasone, pomalidomide and dexamethasone, or dexamethasone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NITYR

Products Affected

- Nityr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

NOCDURNA

Products Affected

- Nocdurna

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hyponatremia or a history of hyponatremia, Polydipsia, Concomitant use with loop diuretics or systemic or inhaled glucocorticoids, Estimated glomerular filtration rate below 50 mL/min/1.73 m2, Syndrome of inappropriate antidiuretic hormone secretion (SIADH), During illnesses that can cause fluid or electrolyte imbalance, Heart failure, Uncontrolled hypertension.
Required Medical Information	Nocturnal polyuria: diagnosis has been confirmed with a 24-hour urine collection and member is awakening at least 2 times per night to void. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

NOCTIVA

Products Affected

- Noctiva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in members with: Hyponatremia or a history of hyponatremia, Polydipsia, Primary nocturnal, Concomitant use with loop diuretics, Concomitant use with systemic or inhaled glucocorticoids, Renal impairment with an estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m2, Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion, During illnesses that can cause fluid or electrolyte imbalance, such as gastroenteritis, salt-wasting nephropathies, or systemic infection, Congestive heart failure (New York Heart Association Class II to IV), and Uncontrolled hypertension.
Required Medical Information	Nocturnal polyuria: diagnosis has been confirmed with a 24-hour urine collection and member is awakening at least 2 times per night to void. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. The requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Patients currently on Northera must experience a sustained decrease in dizziness.

NP AUTO IMMUNE

Products Affected

- Actemra
- Actemra Actpen
- Cimzia
- Cimzia Starter Kit
- Cosentyx
- Cosentyx Sensoready Pen
- Enbrel
- Enbrel Mini
- Enbrel Sureclick
- Ilumya
- Kineret
- Olumiant TABS 2MG
- Orencia
- Orencia Clickject
- Otezla
- Rinvoq
- Simponi
- Simponi Aria
- Skyrizi
- Stelara
- Taltz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Moderate to severe chronic plaque psoriasis (PsO): Psoriasis Area and Severity Index (PASI) score of 10 or more and body surface area (BSA) involvement equal to or greater than 5% OR affecting crucial body areas such as the hands, feet, face, or genitals. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist, Dermatologist, Gastroenterologist, Neurologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	Rheumatoid Arthritis (RA), Psoriatic arthritis (PsA): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab) AND Xejlanz/Xeljanz XR (tofacitinib). Polyarticular juvenile idiopathic arthritis (JIA), ankylosing spondylitis (AS), PsO, Crohn's disease (CD): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab). Ulcerative colitis (UC): Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab) OR Xeljanz (tofacitinib).

NP GROWTH HORMONE

Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Humatrope Combo Pack
- Nutropin Aq Nuspin 5
- Nutropin Aq Pen
- Omnitrope
- Saizen
- Saizenprep Reconstitutionkit
- Zomacton

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Active malignancy.
Required Medical Information	Growth Hormone Deficiency in Children and Adolescents: Member has failed to respond to at least 2 standard GH stimulation tests. One abnormal GH test is sufficient for children with brain tumors and irradiation with documented multiple pituitary hormone deficiency (MPHD) AND Appropriate imaging (MRI or CT) of the brain to exclude tumor on hypothalamic-pituitary region. One of the following criteria are met: Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex OR Child has moderate growth retardation with height SDS –2 and –3 SDS below the mean chronological age and sex and decreased growth rate (growth velocity measured over one year below 25th percentile for age and sex) OR Child exhibits severe deceleration in growth rate (growth velocity measured over 1 year –2 SDS below the mean for age and sex) OR Child has decreasing growth rate combined with a predisposing condition like previous cranial irradiation or tumor OR Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus). GH Deficiency in Adults: Covered for adult GH deficiency who meet ALL the following criteria: Adult onset: Members who have GH deficiency either alone or with multiple hormone deficiencies (hypopituitarism), as a result of EITHER disease of the pituitary or hypothalamus OR injury to either the pituitary or hypothalmus from surgery, radiation therapy, or trauma OR Childhood onset: Members who were GH deficient during childhood who have GH deficiency confirmed as adult before therapy is started. AND Biochemical diagnosis of GH deficiency, by means of a negative response to two standard GH stim tests (maximum peak less than 5 ng/ml when measured by RIA or less than 2.5 ng/ml when measured by IRMA) AND Members already receiving supplementation of other hormones as required AND Objective measurement of clinical features of GH deficiency.

Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist or Nephrologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Genotropin. If using target medication for a medically-accepted indication not shared by Genotropin, then no trial of Genotropin is required for that target medication.

NP MULTIPLE SCLEROSIS

Products Affected

- Aubagio
- Avonex
- Avonex Pen
- Copaxone INJ 20MG/ML, 40MG/ML
- Extavia
- Lemtrada
- Mavenclad
- Mayzent
- Ocrevus
- Plegridy
- Plegridy Starter Pack
- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack
- Tecfidera
- Tecfidera Starter Pack
- Zinbryta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Relapsing or primary progressive forms of multiple sclerosis (MS): Documentation that other therapies used for treating MS will be discontinued (Note: This does NOT require having to discontinue Ampyra (dalfampridine)).The member has a diagnosis of a relapsing form of MS, a primary progressive form of MS OR has experienced a first clinical episode and has MRI features consistent with MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Neurologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Relapsing MS: Member must have tried and failed, or has a contraindication or intolerance to two of the following: Ampyra (dalfampridine), Betaseron (interferon beta-1b), Gilenya (fingolimod), glatiramer, Glatopa (glatiramer).

NPLATE

Products Affected

- Nplate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Will not be used concomitantly with other approved platelet stimulating factors such as Promacta (eltrombopag).

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of severe asthma: Documentation of eosinophilic phenotype AND failure of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists. Renewal: through end of plan contract year if demonstrated benefit, meeting at least 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of therapy)) OR FEV1 improvement (12% or greater from baseline (prior to start of therapy)) OR reduction in symptoms (wheezing, shortness of breath, cough, chest tightness) OR reduction in systemic corticosteroids and rescue drug use OR reduction of asthma-related hospitalizations and other medical contacts OR improvement in baseline eosinophil blood count on while on medication (1st reauthorization only), OR member has utilized the medication for greater than 24 months and has remained stable.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, immunologist, or pulmonologist
Coverage Duration	Initial approval: 6 months. Renewal: Through end of plan contract year.
Other Criteria	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUTRESTORE

Products Affected

- Nutrestore

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Short Bowel Syndrome (SBS): Member is receiving specialized nutritional support in conjunction with a recombinant human growth hormone that is approved for this indication.
Age Restrictions	N/A
Prescriber Restrictions	SBS: Gastroenterologist
Coverage Duration	16 weeks
Other Criteria	N/A

NUVIGIL

Products Affected

- Armodafinil
- Nuvigil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUZYRA

Products Affected

- Nuzyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of susceptible bacteria based on: 1) culture and susceptibility information OR 2) local epidemiology and susceptibility patterns. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial and renewal: 14 days
Other Criteria	N/A

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Complete biliary obstruction.
Required Medical Information	For primary biliary cholangitis (PBC): used in combination with ursodeoxycholic acid (UDCA) in an adult member who has not achieved an adequate biochemical response (adequate response to UDCA defined as serum bilirubin less than 1 mg/dL, aspartate aminotransferase (AST) less than 2 times the upper limit of normal, and alkaline phosphatase (ALP) less than 3 times the upper limit of normal at the end of the first year of therapy) to an appropriate dosage of UDCA for at least 1 year, unless the member has a documented intolerance to UDCA.
Age Restrictions	N/A
Prescriber Restrictions	For PBC: Hepatologist or gastroenterologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

OCTREOTIDE

Products Affected

- Octreotide Acetate
- Sandostatin
- Sandostatin Lar Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas and adrenal gland.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease. For meningiomas: patient has unresectable disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis: Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For idiopathic pulmonary fibrosis continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OLYSIO

Products Affected

- Olysio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

ONFI

Products Affected

- Clobazam
- Onfi SUSP
- Onfi TABS 10MG, 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONIVYDE

Products Affected

- Onivyde

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

OPDIVO

Products Affected

- Opdivo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORACEA

Products Affected

- Doxycycline CPDR
- Oracea

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to formulary generic topical metronidazole.

ORALAIR

Products Affected

- Oralair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in members with severe, unstable or uncontrolled asthma OR history of any severe systemic allergic reaction OR history of any severe local reaction after taking any sublingual allergen immunotherapy OR a history of eosinophilic esophagitis.
Required Medical Information	Member has a diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in this product.
Age Restrictions	Covered for members 10 through 65 years of age.
Prescriber Restrictions	Allergist, immunologist, or pulmonologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to a nasal corticosteroid AND an oral or nasal antihistamine.

ORAL-INTRANASAL FENTANYL

Products Affected

- Fentanyl Citrate TABS
- Fentora TABS 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hepatic impairment (Child Pugh Class C).
Required Medical Information	PAH: Pulmonary Arterial Hypertension (PAH) (WHO Group 1) member has mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Pulmonologist or cardiologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORILISSA

Products Affected

- Orilissa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.

OSPHENA

Products Affected

- Osphena

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Undiagnosed abnormal genital bleeding, Known or suspected estrogen-dependent neoplasia, Active DVT or pulmonary embolism (PE) or a history of these conditions, Active arterial thromboembolic disease (for example, stroke and myocardial infarction [MI]) or a history of these conditions, Known or suspected pregnancy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Ophthalmologist or Optometrist
Coverage Duration	8 weeks
Other Criteria	N/A

OXYCODONE HCL ER

Products Affected

- Oxycodone Hcl Er T12A
- Oxycontin T12A

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression, Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, Known or suspected gastrointestinal obstruction, including paralytic ileus. As an as-needed (prn) analgesic.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Chronic pain: Member must have tried and failed, or has a contraindication or intolerance to two (2) alternative formulary long-acting opioids such as Hysingla ER, controlled-release morphine, fentanyl patches.

PALYNZIQ

Products Affected

- Palynziq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months. Continuation of treatment: Plan Year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Kuvan (sapropterin)

PEGASYS

Products Affected

- Pegasys
- Pegasys Proclick INJ 180MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis).
Exclusion Criteria	N/A
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
Other Criteria	N/A

PEG-INTRON

Products Affected

- Pegintron INJ 50MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C Virus (HCV): HCV infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history and response if applicable, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: Duration will be applied consistent with current AASLD/IDSA guidance, All others: 6 months
Other Criteria	HCV: Criteria will be applied consistent with current AASLD-IDSA guidance.

PERFOROMIST

Products Affected

- Perforomist

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	COPD: Member must have tried and failed, or has a contraindication or intolerance to Bevespi Aerosphere (glycopyrrolate/formoterol Fumarate) and Serevent Diskus (salmeterol xinafoate). Drug is also subject to a Part B versus Part D coverage determination.

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

PHENOBARBITAL-AGE EDIT

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Seizures: Member must have tried and failed, or has a contraindication or intolerance to one non-High Risk Medication (HRM) alternative formulary drug (such as carbamazepine, lamotrigine, or topiramate).

PHENYLBUTYRATE

Products Affected

- Buphenyl TABS
- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, ixazomib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PORTRAZZA

Products Affected

- Portrazza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

POTELIGEO

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

PPI

Products Affected

- Nexium I.v. INJ 40MG
- Zegerid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	A documented trial of one month each of two of the following formulary generic proton pump inhibitors (PPIs): lansoprazole, omeprazole, covered omeprazole/bicarbonate, pantoprazole, esomeprazole sodium, or esomeprazole magnesium UNLESS being used for reduction of risk of upper GI bleed in critically ill patients.

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROCYSBI

Products Affected

- Procysbi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are hypersensitive to penicillamine.
Required Medical Information	Nephropathic cystinosis: Diagnosis confirmed by the presence of increased cysteine concentration in leukocytes or by genetic testing. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	Nephropathic cystinosis: Member must have tried and failed, or has a contraindication or intolerance to Cystagon (cysteamine bitartrate).

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) untransfused platelet count at any point prior to the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) current plt count is less than or equal to 200,000/mcL OR b) current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For continuation of therapy, plt count response to the requested drug: a) current plt count is 50,000-200,000/mcL, OR b) current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR c) current plt count is less than 50,000/mcL and patient is transfusion-independent, OR d) current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV:6mo, INITIAL: ITP/AA-6mo, REAUTH: 1) ITP/AA APR-Plan Yr, 2) AA IPR-16wks
Other Criteria	APR: adequate platelet response (greater than 50k/mcL), IPR: inadequate platelet response (less than 50k/mcL)

PULMONARY HYPERTENSION-OTHER

Products Affected

- Epoprostenol Sodium
- Flolan
- Tyvaso
- Tyvaso Refill
- Tyvaso Starter
- Veletri

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH: Pulmonary Arterial Hypertension (PAH) (WHO Group 1) member has mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Pulmonologist or cardiologist
Coverage Duration	Initial: 6 months. Renewal: Through end of plan contract year.
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination.

PULMOZYME

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

QUININE SULFATE

Products Affected

- Qualaquin
- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

QUTENZA

Products Affected

- Qutenza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Postherpetic Neuralgia (PHN): Member must have tried and failed, or has a contraindication or intolerance to one month of generic gabapentin.

RADICAVA

Products Affected

- Radicava

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	ALS: Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	Amyotrophic lateral sclerosis (ALS): Member must have tried and failed, or has a contraindication or intolerance to riluzole.

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Ravicti will be used for chronic management of UCD. Patient has experienced intolerance to prior Buphenyl therapy OR patient has not tried Buphenyl because of a comorbid condition that prohibits a trial due to its sodium content (e.g., heart failure, hypertension, renal impairment, edema).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	N/A

RELISTOR

Products Affected

- Relistor TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction. At increased risk of recurrent obstruction due to the potential for gastrointestinal perforation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 Months
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Amitiza (lubiprostone) and Movantik (naloxegol).

RELISTOR INJ

Products Affected

- Relistor INJ

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

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, covered formulary mesalamine) OR 2) intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RENFLEXIS

Products Affected

- Renflexis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Doses greater than 5 mg/kg should not be administered to patients with moderate to severe heart failure (New York Heart Association [NYHA] Functional Class III/IV).
Required Medical Information	Chronic severe (i.e., extensive and/or disabling) plaque psoriasis (PsO): Psoriasis Area and Severity Index (PASI) score of 10 or more and body surface area (BSA) involvement equal to or greater than 10% OR affecting crucial body areas such as the hands, feet, face, or genitals. For fistulizing Crohn's disease: Require diagnosis of fistulizing disease. Renewal: Member’s condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Rheumatologist, Dermatologist, Ophthalmologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year

Other Criteria	Moderate to severely active Crohn's disease (CD): Member must have tried and failed, or has a contraindication or intolerance to one corticosteroid such as prednisone, budesonide, methylprednisolone AND Remicade (infliximab injection) OR Humira (adalimumab). Moderate to severe active ulcerative colitis (UC): Member must have tried and failed, or has a contraindication or intolerance to one 5-aminosalicylic acid product (5-ASA) such as sulfasalazine, mesalamine, balsalazide, or one corticosteroid such as prednisone or methylprednisolone AND Remicade (infliximab injection), Humira (adalimumab), or Xeljanz (tofacitinib). Moderate to severely active rheumatoid arthritis (RA): Member must have tried and failed, or has a contraindication or intolerance to two of the following: Remicade (infliximab injection), Humira (adalimumab) or Xeljanz/XR (tofacitinib). Ankylosing spondylitis (AS): Member must have tried and failed, or has a contraindication or intolerance to a non-steroidal anti-inflammatory drug (NSAID) AND Remicade (infliximab injection) OR Humira (adalimumab). Active psoriatic arthritis (PsA): Member must have tried and failed, or has a contraindication or intolerance to one corticosteroid such as dexamethasone or methylprednisolone AND Remicade (infliximab injection) OR Humira (adalimumab) OR Xeljanz/XR (tofacitinib). Chronic severe PsO: Member must have tried and failed, or has a contraindication or intolerance to cyclosporine or methotrexate or methoxsalen with UVA light (PUVA) AND Remicade (infliximab injection) or Humira (adalimumab).

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member must have one of the following conditions (new starts and renewal): 1) Homozygous Familial Hypercholesterolemia (HoFH), 2) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Other Criteria) OR, 3) Heterozygous familial hypercholesterolemia (HeFH): Diagnosis of FH (See Other Criteria). For new starts: For members with HoFH: supported by genetic confirmation of two mutant alleles at LDLR, APOB, OCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL (or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 years or heterozygous familial hypercholesterolemia (HeFH) in both parents AND is taking a maximally tolerated dose of any statin unless all statins are contraindicated or not tolerated. For members with prior clinical ASCVD or cardiovascular event, at least one of the following requirements is met: 1) Current low density lipoprotein (LDL-C) level 70 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 2) Current LDL-C level 70 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 3) Current LDL-C level 70 mg/dL or greater with contraindication to statin OR intolerance to any dose of two statins. For members with HeFH, at least one of the following requirements is met: 1) With ASCVD: See requirements for members with prior ASCVD above, 2) Current LDL-C level 100 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 3) Current LDL-C level 100 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 4) Current LDL-C level 100 mg/dL or greater with contraindication to statin OR intolerance to any dose of two statins. Renewal: Response to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist

Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	Will not be used concomitantly with other PCSK9 inhibitors. For HeFH and ASCVD: Member must have tried and failed, or has a contraindication or intolerance to Praluent (alirocumab). Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event is defined as: acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure [eg, PTCA, CABG], stroke of presumed atherosclerotic origin, transient ischemic attack [TIA], non-cardiac peripheral arterial disease of presumed atherosclerotic origin, or obstructive coronary artery disease [defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization]. Diagnosis of FH must be confirmed by one of the following: 1) Genetic confirmation: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for FH: Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL in members over 16 years of age or total cholesterol greater than 260 mg/dl or LDL-C greater than 155 mg/dl in members less than 16 years of age and one of the following: a)Tendon xanthomas in the member, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt), b)Family history of myocardial infarction in a first degree relative at age 60 or younger or in a second degree relative at age 50 or younger, c) Total cholesterol greater than 290 mg/dl in an adult first or second degree relative, d) Total cholesterol greater than 260 mg/dl in a child, brother, or sister aged younger than 16 years. 3) Dutch Lipid Clinic Network Criteria for definite or probable FH: Total score greater than 5 points.

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, myelofibrosis-associated anemia, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic/nodal marginal zone lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma and primary cutaneous anaplastic large cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RHOFADE

Products Affected

- Rhofade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Renewal: Through end of plan contract year
Other Criteria	Rosacea: Member must have tried and failed, or has a contraindication or intolerance to therapy with a formulary generic topical metronidazole.

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) The requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated AND 2) Patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The requested medication will be used in combination with glucocorticoids. For multiple sclerosis: 1) Patient has a diagnosis of relapsing remitting multiple sclerosis and 2) Patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member must have a diagnosis of hereditary angioedema (HAE) where diagnosis is documented based on evidence of a normal C1 level and a low C4 level (C4 less than 14 mg/dL [normal range 14 to 40 mg/dL], or C4 below the lower limit of normal as defined by the laboratory performing the test) plus: a) A low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL [normal range 19 to 37 mg/dL] or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test) OR b) A normal C1INH antigenic level (C1INH greater than or equal to 19 mg/dL) and a low C1INH functional level (functional C1INH less than 50%, or below the lower limit of normal as defined by the laboratory performing the test) and Member must be experiencing at least one symptom of the moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion) and Medications known to cause angioedema (i.e., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.
Age Restrictions	N/A
Prescriber Restrictions	Immunologist or Rheumatologist or Allergist
Coverage Duration	Through end of plan contract year.
Other Criteria	Will not be used concomitantly with other approved treatments for acute HAE attacks. Prescriber is aware that drug is a contraindication to members allergic to rabbits or rabbit-derived products.

RUZURGI

Products Affected

- Ruzurgi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizures
Required Medical Information	N/A
Age Restrictions	6 to less than 17 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For newly diagnosed FLT3 mutation-positive acute myeloid leukemia (AML), the requested medication is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment is being initiated or re-initiated in a hospital where serum sodium can be monitored closely.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

SAVELLA

Products Affected

- Savella
- Savella Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of a Monoamine Oxidase Inhibitors (MAOI).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to duloxetine and Lyrica (pregabalin).

SEROSTIM

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member must have the diagnosis of AIDS wasting and/or cachexia. The member must be on anti-viral therapy and compliant with their regimen. The member must be evaluated for inadequate nutritional intake, malabsorption, opportunistic infections, and/or hyopgonadism as a potential cause for weight loss. The member has progressive weight loss of greater than 10% of body weight from pre-illness. The patient has a body mass index (BMI) less than 20. Renewal: Member has not had further weight loss while on therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 12 weeks. Renewal: 3 month periods: Maximum: 48 weeks
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIGNIFOR LAR

Products Affected

- Signifor Lar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly: 1) Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the member has not had surgery or radiotherapy. Renewal for acromegaly: member's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

SILDENAFIL

Products Affected

- Revatio
- Sildenafil INJ
- Sildenafil Citrate SUSR
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SILIQ

Products Affected

- Siliq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in members with Crohn's disease.
Required Medical Information	Moderate to severe chronic plaque psoriasis (PsO): Psoriasis Area and Severity Index (PASI) score of 10 or more and body surface area (BSA) involvement equal to or greater than 5% OR affecting crucial body areas such as the hands, feet, face, or genitals. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	PsO: Dermatologist, Rheumatologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	PsO: Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab).

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

SOFOSBUVIR - VELPATASVIR

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have tried and failed, or has a contraindication or intolerance to 2 of the following if appropriate based on current AASLD/IDSA guidance: Epclusa (brand only), Harvoni (brand only), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

SOLIRIS

Products Affected

- Soliris

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment of members with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS). Members with unresolved serious Neisseria meningitidis infection. Members who are not currently vaccinated against Neisseria meningitidis, unless the risks of delaying treatment outweigh the risks of developing a meningococcal infection.
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Paroxysmal nocturnal hemoglobinuria (PNH), atypical hemolytic uremic syndrome (aHUS): Oncologist or Hematologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

SOMATULINE DEPOT

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas, and adrenal gland.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient meets both of the following criteria: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SORIATANE

Products Affected

- Acitretin
- Soriatane CAPS 10MG, 17.5MG, 25MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered in pregnant females.
Required Medical Information	Indicated for the treatment of severe psoriasis in adults as monotherapy or in combination with phototherapy.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist or Dermatologist
Coverage Duration	6 months
Other Criteria	Psoriasis: Member must have tried and failed, or has a contraindication or intolerance to methotrexate or cyclosporine.

SOVALDI

Products Affected

- Sovaldi TABS 400MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have tried and failed, or has a contraindication or intolerance to 2 of the following if appropriate based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

SPRIX

Products Affected

- Sprix

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. In the setting of coronary artery bypass graft (CABG) surgery. Members with active peptic ulcer disease or members with recent gastrointestinal bleeding or perforation. Members with advanced renal disease or members at risk for renal failure due to volume depletion. Use in labor and delivery. Use in members with suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis, or those for whom hemostasis is critical. Concomitant use with probenecid or pentoxifylline.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 days
Other Criteria	The member is unable to tolerate oral medications.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, progressive GIST.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. The patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypophosphatasia (HPP): The member must have a diagnosis of perinatal - onset , infantile - onset , or juvenile - onset hypophosphatasia defined by: Low total serum alkaline phosphatase (ALP) activity determined by the gender -and age - specific reference range , AND Elevated urine concentration of phosphoethanolamine (PEA) determined by age - specific reference range , OR Elevated serum pyridoxal 5' - phosphate (PLP) level (normal range 5 – 50 mcg/L), OR Documented gene mutation of tissue - nonspecific alkaline phosphatase (TNSALP).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

SUBLOCADE

Products Affected

- Sublocade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prescribed only for the diagnosis of pain.
Required Medical Information	Opioid use disorder is moderate to severe. Member has initiated/will initiate treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of 7 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For obstructive sleep apnea (OSA): confirmation that the underlying airway obstruction is treated (e.g., with continuous positive airway pressure (CPAP)) for at least one month prior to initiating SUNOSI for excessive daytime sleepiness.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), thymic carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis, polycythemia vera, essential thrombocythemia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYLVANT

Products Affected

- Sylvant

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multicentric Castleman's disease (MCD): member is HIV negative and human herpesvirus-8 (HHV-8) negative. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist or Rheumatologist
Coverage Duration	6 months
Other Criteria	N/A

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductase regulator (CFTR) gene or the patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The patient has a diagnosis of type 1 or type 2 diabetes mellitus AND 2) The patient is currently receiving optimal mealtime insulin therapy AND 3) The patient has experienced an inadequate treatment response to insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

SYNERA

Products Affected

- Synera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	For topical local anesthetic to skin: Member must have tried and failed, or has a contraindication or intolerance to a one month trial of generic topical lidocaine/prilocaine.

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TADALAFIL (PAH)

Products Affected

- Adcirca
- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma.
Exclusion Criteria	N/A
Required Medical Information	For melanoma (including brain metastases), tumor is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For NSCLC, tumor is positive for a BRAF V600 activating mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, EGFR mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases if active against primary tumor (EGFR T790M mutation-positive non-small cell lung cancer).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAKHZYRO

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (eg, levocetirizine) for at least one month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TARCEVA

Products Affected

- Erlotinib Hydrochloride
- Tarceva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	For CML or ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazorac

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECHNIVIE

Products Affected

- Technivie

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe hepatic impairment (Child-Pugh B and C).
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TESTOSTERONE

Products Affected

- Androgel
- Androgel Pump GEL 1.62%
- Fortesta
- Natesto
- Striant
- Testim
- Vogelxo
- Vogelxo Pump

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Testosterone levels within normal range (range for the lab doing the testing). Female patients. Men with carcinoma of the breast or suspected carcinoma of the prostate. Use for muscle building purposes.
Required Medical Information	For members initiating testosterone replacement therapy: Testosterone levels (total or free). Require either ONE low total testosterone level OR ONE low free testosterone level (normal ranges as provided by office or clinic performing labs). Note: Members that are already stabilized will not be required to provide labs and can be approved as continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Androderm (testosterone patch) or generic testosterone gel.

TESTOSTERONE INJ

Products Affected

- Depo-testosterone INJ 100MG/ML, 200MG/ML
- Testopel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Testosterone levels within normal range (range for the lab doing the testing). Female patients. Men with carcinoma of the breast or suspected carcinoma of the prostate. Use for muscle building purposes.
Required Medical Information	For members initiating testosterone replacement therapy: Testosterone levels (total or free). Require either ONE low total testosterone level OR ONE low free testosterone level (normal ranges as provided by office or clinic performing labs). Note: Members that are already stabilized will not be required to provide labs and can be approved as continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to generic testosterone enanthate or testosterone cypionate.

TESTRED

Products Affected

- Methitest
- Methyltestosterone CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Men with carcinomas of the breast or with known or suspected carcinomas of the prostate. Women who are or may become pregnant.
Required Medical Information	Males: Primary hypogonadism (congenital or acquired), Hypogonadotropic hypogonadism (congenital or acquired), Delayed puberty. For diagnosis of delayed puberty, an X-ray of the hand and wrist will be performed to determine bone age every six months to assess the effect of treatment on the epiphyseal centers. Females: Advancing inoperable metastatic (skeletal) mammary cancer and 1 to 5 years postmenopausal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Delayed Puberty: 6 months. All Other Diagnoses: Through end of plan contract year.
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis-related anemia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	N/A
Required Medical Information	Cachexia: Cachexia must be due to cancer or HIV infection. Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THIORIDAZINE-AGE EDIT

Products Affected

- Thioridazine Hcl TABS 100MG, 10MG, 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two formulary alternative non-High Risk Medication (HRM) drugs (such as aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone).

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TOBI

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TOLAK

Products Affected

- Tolak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are pregnant or may become pregnant. Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

TOLSURA

Products Affected

- Tolsura

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year
Other Criteria	N/A

TOPICAL DOXEPIN

Products Affected

- Doxepin Hydrochloride CREA
- Prudoxin
- Zonalon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with untreated narrow angle glaucoma or a tendency to urinary retention.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

TOPICAL LIDOCAINE

Products Affected

- Lidocaine OINT
- Lidocaine/prilocaine CREA
- Pliaglis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	1) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 2) Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL NSAIDS

Products Affected

- Diclofenac Sodium GEL
- Diclofenac Sodium TRANSDERMAL SOLN 1.5%
- Klofensaid II
- Pennsaid SOLN 2%
- Solaraze
- Voltaren GEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Osteoarthritis: Member must have tried and failed, or has a contraindication or intolerance to two formulary generic oral Nonsteroidal Anti-inflammatory Drugs (NSAIDs).

TOPICAL TESTOSTERONES

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOPICAL TRETINOIN

Products Affected

- Adapalene CREA
- Adapalene GEL
- Adapalene PADS
- Adapalene SOLN
- Adapalene/benzoyl Peroxide
- Altreno
- Atralin
- Avita
- Clindamycin Phosphate/tretinoin
- Differin CREA
- Differin GEL
- Differin LOTN
- Epiduo
- Epiduo Forte
- Plixda
- Retin-a CREA
- Retin-a GEL
- Retin-a Micro
- Retin-a Micro Pump
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump
- Ziana

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRASTUZUMAB

Products Affected

- Kanjinti INJ 420MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TREATMENT OF ATTENTION DEFICIT DISORDER - AGE EDIT

Products Affected

- Adderall
- Adderall Xr
- Adzenys Er
- Adzenys Xr-odt
- Amphetamine/dextroamphetamine
- Aptensio Xr
- Concerta
- Cotempla Xr-odt
- Daytrana
- Desoxyn
- Dexedrine CP24
- Dexmethylphenidate Hcl
- Dexmethylphenidate Hcl Er
- Dexmethylphenidate Hydrochloride TABS 2.5MG, 5MG
- Dextroamphetamine Sulfate SOLN
- Dextroamphetamine Sulfate TABS
- Dextroamphetamine Sulfate Er
- Dyanavel Xr
- Focalin
- Focalin Xr
- Metadate Er TBCR 20MG
- Methamphetamine Hcl
- Methylin SOLN
- Methylphenidate Hydrochloride
- Methylphenidate Hydrochloride CD CPCR 10MG, 20MG, 30MG, 50MG, 60MG
- Methylphenidate Hydrochloride Er CP24
- Methylphenidate Hydrochloride Er CPCR 40MG
- Methylphenidate Hydrochloride Er TB24
- Methylphenidate Hydrochloride Er TBCR
- Methylphenidate Hydrochloride Er (la)
- Mydayis
- Procentra
- Quillichew Er
- Quillivant Xr
- Relexxii
- Ritalin
- Ritalin La CP24 10MG, 20MG, 30MG, 40MG
- Vyvanse
- Zenzedi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.

Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TRELSTAR

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

TREMFYA

Products Affected

- Tremfya

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Moderate to severe chronic plaque psoriasis (PsO): Psoriasis Area and Severity Index (PASI) score of 10 or more and body surface area (BSA) involvement equal to or greater than 5% OR affecting crucial body areas such as the hands, feet, face, or genitals. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	PsO: Dermatologist, Rheumatologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	PsO: Member must have tried and failed, or has a contraindication or intolerance to Humira (adalimumab).

TREPROSTINIL INJ

Products Affected

- Remodulin
- Treprostinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRIENTINE

Products Affected

- Syprine
- Trientine Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRIPTODUR

Products Affected

- Triptodur

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in pregnancy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

TRULANCE

Products Affected

- Trulance

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	N/A
Age Restrictions	Covered for members 18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Chronic idiopathic constipation (CIC)/Irritable bowel syndrome with constipation (IBS-C): Member must have tried and failed, or has a contraindication or intolerance to Amitiza (lubiprostone) and Linzess (linaclotide).

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions from HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), or 2) capecitabine, or 3) trastuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cumulative use of abaloparatide injection and parathyroid hormone analogs (e.g., teriparatide) for more than 2 years during member's lifetime.
Required Medical Information	Postmenopausal Women with Osteoporosis at High Risk for Fracture: Documentation of both of the following: (1) Bone Mineral Density (BMD) T-score of -2.5 or more standard deviations below the mean AND (2) Postmenopausal woman is at high risk for fracture as defined by the presence of two of the following: (a) osteoporotic fracture history, (b) multiple risk factors for fracture, (c) failure or intolerance to other available osteoporosis therapies. All Diagnoses: Start date of therapy (maximum cumulative therapy duration of abaloparatide injection and parathyroid hormone analogs (e.g., teriparatide) is 2 years of therapy per lifetime) and Previous therapy duration of any parathyroid hormone analog use (e.g., teriparatide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Will not be used concomitantly with Prolia (denosumab injection) or other parathyroid hormone analogs (e.g., teriparatide). Postmenopausal Women with Osteoporosis at High Risk for Fracture: Member must have tried and failed, or has a contraindication or intolerance to Forteo (teriparatide) AND Prolia (denosumab injection).

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (e.g., corticosteroid, azathioprine, mesalamine) AND one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

UDENYCA

Products Affected

- Udenyca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	For diagnosis of cancer and receiving myelosuppressive chemotherapy: documented trial of 8 weeks of Neupogen.

ULTOMIRIS

Products Affected

- Ultomiris

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with unresolved serious Neisseria meningitidis infection. Members who are not currently vaccinated against Neisseria meningitidis, unless the risks of delaying treatment outweigh the risks of developing a meningococcal infection.
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH: Pulmonary Arterial Hypertension (PAH) (WHO Group 1) AND patient has mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Pulmonologist or cardiologist
Coverage Duration	Initial: 6 months. Renewal: Through end of plan contract year.
Other Criteria	N/A

VABOMERE

Products Affected

- Vabomere

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease Specialist, or the prescriber has obtained a consult with an infectious disease specialist
Coverage Duration	14 days
Other Criteria	N/A

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic or smoldering adult T-cell leukemia/lymphoma, mycosis fungoides, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VECAMYL

Products Affected

- Vecamyl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in coronary insufficiency or recent myocardial infarction, or in patients with uremia, glaucoma, or organic pyloric stenosis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of a two-drug combination from the preferred alternatives from the following classes: Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists. Beta-Adrenergic Blockers, Calcium Channel Blockers.

VECTIBIX

Products Affected

- Vectibix INJ 100MG/5ML, 400MG/20ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Ras-mutant colorectal cancer.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only. Will not be used concomitantly with Avastin (bevacizumab), Erbitux (cetuximab), or Tarceva (erlotinib).

VELCADE

Products Affected

- Bortezomib
- Velcade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, mantle cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIBATIV

Products Affected

- Vibativ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of intravenous unfractionated heparin sodium.
Required Medical Information	Diagnosis confirmed by culture showing susceptibility to the medication.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	1 month
Other Criteria	If culture shows susceptibility to vancomycin, member must have tried and failed, or has a contraindication or intolerance to vancomycin.

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members without a gallbladder, biliary duct obstruction, alcoholism, history of pancreatitis, severe hepatic impairment (Child-Pugh Class C), history of chronic or severe constipation or sequelae from constipation, or known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to generic loperamide.

VIDAZA

Products Affected

- Azacitidine
- Vidaza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with advanced malignant hepatic tumors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

VIEKIRA

Products Affected

- Viekira Pak
- Viekira Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Member must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir), Zepatier (elbasvir and grazoprevir) AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

VIGABATRIN

Products Affected

- Sabril
- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 covered formulary alternatives therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIMIZIM

Products Affected

- Vimizim

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Type 1 Gaucher disease: Diagnosis of Type 1 Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and member has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly). Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

VRAYLAR

Products Affected

- Vraylar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VUSION

Products Affected

- Miconazole Nitrate/zinc Oxide/white Petrolatum
- Vusion

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of diaper dermatitis caused by candida AND confirmed by microscopic evidence of pseudohyphae and/or budding yeast (e.g. KOH).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYXEOS

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

WAKIX

Products Affected

- Wakix

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The patient has narcolepsy confirmed by sleep lab evaluation AND 2) The patient has experienced an inadequate treatment response or intolerance to a central nervous system (CNS) stimulant (e.g., amphetamine, dextroamphetamine, methylphenidate) OR has a contraindication that would prohibit the trial of central nervous system (CNS) stimulants [Note: Coverage of amphetamines may require prior authorization.] AND 3) The patient has experienced an inadequate treatment response or intolerance to armodafinil OR has a contraindication that would prohibit the trial of armodafinil [Note: Coverage of armodafinil may require prior authorization.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	N/A
Required Medical Information	For IMT, the tumor is ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), AND 2) The requested drug is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.). For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XENAZINE

Products Affected

- Tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are actively suicidal, or with untreated or inadequately treated depression. Impaired hepatic function. Currently taking monoamine oxidase inhibitors.
Required Medical Information	Huntington's Disease (initial): Diagnosis of chorea in members with Huntington's disease. Tardive dyskinesia and Tourette's syndrome (initial): Member has stereotypes associated with tardive dyskinesia or patient has tics associated with Tourette's syndrome. Renewal (all diagnoses): Member's condition is stable or showing clinical improvement.
Age Restrictions	Tardive dyskinesia: Covered for members 18 years of age and older.
Prescriber Restrictions	Huntington: Prescribed by a neurologist. Tardive dyskinesia, Tourette: Prescribed by neurologist or psychiatrist.
Coverage Duration	Initial: 3 months, Renewal: Through end of plan contract year
Other Criteria	Tics associated with Tourette's syndrome: Member must have tried and failed, or has a contraindication or intolerance to haloperidol.

XEOMIN

Products Affected

- Xeomin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic Use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	Blepharospasm: Member must have tried and failed, or has a contraindication or intolerance to onabotulinumtoxin A (Botox).

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Renewal: Through end of plan contract year
Other Criteria	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Applies to new starts only.

XIAFLEX

Products Affected

- Xiaflex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Peyronie's disease: treatment of Peyronie's plaques that involve the penile urethra due to potential risk to this structure.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Reduction in risk of overt HE recurrence - 6 Months, IBS-D and all other indications - Plan Year
Other Criteria	N/A

XIIDRA

Products Affected

- Xiidra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Comprehensive eye exam that includes one of the following tests for symptoms of dry eye: Corneal Fluorescein Staining (CFS) or Schirmer Tear Test (STT) and one of the following tests for signs of dry eye: Eye Dryness Score (EDS) or Ocular Discomfort Score (ODS).
Age Restrictions	N/A
Prescriber Restrictions	Ophthalmologist or Optometrist or Rheumatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Dry eye disease (DED): Member must have tried and failed, or has a contraindication or intolerance to Restasis (cyclosporine emulsion).

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For allergic asthma initial therapy: 1)Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on the requested drug since initiation of therapy. Chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

XPOVIO

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used to treat prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Orotic aciduria type I (OA1) (Hereditary orotic aciduria): Diagnosis has been confirmed by a urine test with elevated levels of orotic acid or a genetic test showing mutations of the uridine monophosphate synthetase (UMPS) gene. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months, Renewal: Through end of plan contract year
Other Criteria	N/A

XYOSTED

Products Affected

- Xyosted

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Testosterone levels within normal range (range for the lab doing the testing). Female patients. Men with carcinoma of the breast or suspected carcinoma of the prostate. Use for muscle building purposes.
Required Medical Information	For members initiating testosterone replacement therapy: Testosterone levels (total or free). Require either ONE low total testosterone level OR ONE low free testosterone level (normal ranges as provided by office or clinic performing labs). Note: Members that are already stabilized will not be required to provide labs and can be approved as continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Androderm AND one of the following: generic testosterone enanthate or generic testosterone cypionate.

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The drug is being prescribed for the treatment of excessive daytime sleepiness in a patient with narcolepsy AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS stimulant drug and one CNS promoting wakefulness drug OR 3) the patient has a contraindication to at least one CNS stimulant drug and one CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a CNS wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem (sodium oxybate), then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, CNS metastases from primary tumor (melanoma), small cell lung cancer
Exclusion Criteria	N/A
Required Medical Information	For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma) AND 2) the disease is recurrent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic castration-resistant prostate cancer: 1) Patient has been previously treated with Xtandi (enzalutamide) unless the patient has a contraindication to Xtandi (enzalutamide) therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	N/A

YOSPRALA

Products Affected

- Yosprala

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

YUPELRI

Products Affected

- Yupelri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two of the following: Symbicort (budesonide/formoterol), Advair Diskus (fluticasone/salmeterol), Breo Ellipta (fluticasone/vilanterol), Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium bromide/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone furoate/umeclidinium bromide/vilanterol trifenatate). Drug is also subject to a Part B versus Part D coverage determination.

ZALTRAP

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

ZAVESCA

Products Affected

- Miglustat
- Zavesca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma, non-small cell lung cancer, hairy cell leukemia, and thyroid carcinoma (papillary, follicular, and Hurthle).
Exclusion Criteria	N/A
Required Medical Information	For melanoma (including brain metastases), tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma the tumor is positive for BRAF mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZELNORM

Products Affected

- Zelnorm TABS 6MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient with history of myocardial infarction, stroke, transient ischemic attack, or angina, history of ischemic colitis or other forms of intestinal ischemia, severe renal impairment (eGFR less than 15 mL/min/1.73 m2) or end-stage renal disease, moderate or severe hepatic impairment (Child-Pugh B or C) or history of bowel obstruction, symptomatic gallbladder disease, suspected sphincter of Oddi dysfunction, or abdominal adhesions.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Amitiza (lubiprostone) and Linzess (linaclotide).

ZEMDRI

Products Affected

- Zemdri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions (eg, NS5A polymorphisms) where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	To reduce recurrence of Clostridium difficile infection (CDI): Member must have had a previous occurrence of CDI. Confirmed diagnosis of CDI and a positive stool test of C. difficile from a stool sample collected during current episode of CDI. Member is receiving antibacterial drug treatment for CDI and is at high risk for CDI recurrence (i.e., members aged 65 years and older, history of CDI in the past 6 months, immunocompromised state, severe CDI at presentation, or C. difficile ribotype 027).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Infectious disease specialist or Gastroenterologist
Coverage Duration	1 month
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZORBTIVE

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Short bowel syndrome: Member is receiving nutritional support.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

ZTLIDO

Products Affected

- Ztlido

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Post Herpetic Neuralgia (PHN): Member must have tried and failed, or has a contraindication or intolerance to one month of gabapentin.

ZURAMPIC

Products Affected

- Zurampic

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe renal impairment (eCLcr less than 30 mL/min), end stage renal disease, kidney transplant recipients, or members on dialysis. Tumor lysis syndrome or Lesch-Nyhan syndrome.
Required Medical Information	Documentation of estimated creatinine clearance greater than 30 mL/min. Hyperuricemia associated with gout: Member was unable to achieve a target serum uric acid level of less than 6mg/dL with a xanthine oxidase inhibitor alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Hyperuricemia associated with gout: Used in combination with a xanthine oxidase inhibitor such as allopurinol or Uloric (febuxostat).

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory, relapsed or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested medication is used for the treatment of recurrent or metastatic ALK-positive NSCLC. For inflammatory myofibroblastic tumor, the tumor is ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- Zyprexa Relprevv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYTIGA

Products Affected

- Abiraterone Acetate
- Zytiga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D and newly diagnosed metastatic or high-risk locally advanced prostate cancer.
Exclusion Criteria	N/A
Required Medical Information	For metastatic castration-resistant prostate cancer: The requested drug will be used in combination with prednisone. For castration-sensitive metastatic or locally advanced prostate cancer: 1) The requested drug will be used in combination with prednisone and concurrent androgen-deprivation therapy. Androgen deprivation therapy is not required in patients who have had bilateral orchiectomy, 2) Disease is newly diagnosed and metastatic, node-positive, high-risk locally advanced, or was previously treated with radical surgery or radiotherapy and is now relapsing with high risk features.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYVOX

Products Affected

- Linezolid
- Zyvox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered with concomitant use of MAOI therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	Confirmed diagnosis of Vancomycin-resistant Enterococcus faecium Infections OR a trial of three days each of two preferred antibiotics indicated for the members condition such as amoxicillin, moxifloxacin, azithromycin, cephalosporin, clindamycin or dicloxicillin OR Discharge from hospital or medical facility due to a documented diagnosis/covered use AND Documented initial treatment with vancomycin OR intravenous (IV) linezolid while in the hospital/medical facility. For all IV linezolid uses: confirmation member is unable to take oral linezolid.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 10MG, 2MG/ML, 50MG
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Akynzeo CAPS
- Albuterol Sulfate NEBU
- Alkeran TABS
- Ambisome
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes INJ 124MEQ/L; 900MG/100ML; 690MG/100ML; 96MEQ/L; 900MG/100ML; 210MG/100ML; 510MG/100ML; 660MG/100ML; 510MG/100ML; 10MEQ/L; 280MG/100ML; 310MG/100ML; 30MMOLE/L; 65MEQ/L; 610MG/100ML; 300MG/100ML; 65MEQ/L; 370MG/100ML; 120MG/100ML; 44MG/100ML; 560MG/100ML
- Aminosyn 8.5%/electrolytes INJ 142MEQ/L; 1100MG/100ML; 850MG/100ML; 98MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 10MEQ/L; 340MG/100ML; 380MG/100ML; 30MEQ/L; 65MEQ/L; 750MG/100ML; 370MG/100ML; 65MEQ/L; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes

- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML
- Aminosyn-hbc INJ 7.1MEQ/100ML; 660MG/100ML; 507MG/100ML; 660MG/100ML; 154MG/100ML; 789MG/100ML; 1576MG/100ML; 265MG/100ML; 206MG/100ML; 1.12GM/100ML; 228MG/100ML; 448MG/100ML; 221MG/100ML; 272MG/100ML; 88MG/100ML; 33MG/100ML; 789MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf INJ 113MEQ/L; 600MG/100ML; 429MG/100ML; 462MG/100ML; 726MG/100ML; 535MG/100ML; 726MG/100ML; 726MG/100ML; 330MG/100ML; 165MG/100ML; 528MG/100ML
- Amphotericin B INJ
- Anzemet TABS
- Aprepitant
- Astagraf XL
- Atgam
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Baclofen INJ
- Bethkis
- Bleo 15k
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cellcept
- Cellcept Intravenous
- Cesamet
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10% INJ 570MG/100ML; 317MG/100ML; 33MG/100ML; 10GM/100ML; 283MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 2.75%/dextrose 5%
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 5%/dextrose 25%
- Clinimix N14g30e
- Clinimix N9g15e
- Clinimix N9g20e
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS

- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine Aqueous
- Cytovene INJ
- Deferoxamine Mesylate
- Desferal INJ 500MG
- Dextrose 20%
- Dextrose 25% INJ 250MG/ML
- Dextrose 30%
- Dextrose 40%
- Dextrose 50%
- Dextrose 70%
- Dilaudid INJ 1MG/ML, 2MG/ML
- Diphtheria/tetanus Toxoids Adsorbed Pediatric
- Dobutamine Hcl INJ 250MG/20ML, 500MG/40ML
- Dobutamine Hcl/d5w INJ 5%; 1MG/ML
- Dobutamine Hydrochloride/dextrose
- Dopamine Hcl
- Dopamine Hydrochloride/dextrose
- Dopamine/d5w INJ 5%; 3.2MG/ML
- Doxorubicin Hcl INJ 10MG, 2MG/ML, 50MG
- Duopa
- Duramorph
- Emend CAPS
- Emend SUSR
- Emend Tripack
- Engerix-b
- Envarsus Xr
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gamastan
- Gamastan S/d
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hcl TABS
- Hepatamine
- Humulin R U-500 (concentrated)
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML
- Hydromorphone Hydrochloride INJ 1MG/ML, 2MG/ML, 4MG/ML
- Hypertet S/d
- Imovax Rabies (h.d.c.v.)
- Imuran TABS
- Infumorph 200
- Infumorph 500
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Isolyte-s Ph 7.4
- Kabiven
- Kitabis Pak
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.31MG/3ML
- Lioresal Intrathecal
- Melphalan
- Milrinone In Dextrose INJ 5%; 20MG/100ML, 5%; 40MG/200ML

- Milrinone Lactate INJ 10MG/10ML, 20MG/20ML, 50MG/50ML
- Mitigo
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 150MG/30ML, 1MG/ML, 25MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Myfortic
- Nebupent
- Neoral
- Nephramine
- Nulojix
- Nutrilipid
- Omegaven
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Perikabiven
- Plenamine
- Prednisone Intensol
- Premasol
- Prialt
- Procalamine
- Prograf
- Prosol
- Pulmicort
- Rabavert
- Rapamune
- Recombivax Hb
- Sandimmune CAPS 100MG, 25MG
- Sandimmune INJ
- Sandimmune SOLN
- Simulect
- Sirolimus SOLN
- Sirolimus TABS
- Smoflipid
- Synthamin 17
- Tacrolimus CAPS
- Tdvax
- Tenivac
- Thymoglobulin
- Tobi
- Tobramycin NEBU
- Tpn Electrolytes
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trexall
- Trophamine
- Varubi TABS
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Xopenex
- Xopenex Concentrate
- Zofran SOLN
- Zofran TABS 4MG, 8MG
- Zofran Odt
- Zortress
- Zuplenz

Details

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

INDEX

A

B

C

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V