You can contact Humana for the most recent list of drugs by calling 1-800-281-6918 or, for TTY users, 711, five days a week April 1 - September 30 or seven days a week October 1 - March 31 from 8 a.m. - 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting Humana.com.

Prior Authorization Criteria

Effective 12/01/2022

abiraterone

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members with severe hepatic impairment (Child-Pugh Class C). Members that have experienced disease progression while on abiraterone acetate.Concomitant use with Erleada, Xtandi, Provenge, Taxotere or Jevtana.
Required Medical Information	Prostate Cancer (mCRPC). The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC). The member will be using abiraterone acetate in combination with prednisone. Prostate Cancer (mCSPC). The member has diagnosis of castration-sensitive prostate cancer plus one of the following scenarios: metastatic (stage IV) disease AND is high risk (e.g. Gleason score of 8 or more, at least three bone lesions, or presence of measurable visceral metastases) OR Node-positive (any T, N1) OR localized disease with high risk features (e.g. a PSA level greater than 4 ng per milliliter with a doubling time of less than 6 months, a PSA level greater than 20 ng per milliliter, nodal or metastatic relapse, or adjuvant or neoadjuvant therapy lasting less than 12 months of total ADT and completed at least 12 months previously) that is persistent or recurrent after prior radical prostatectomy and/or radiation therapy. Member will be using abiraterone acetate in combination with prednisone and one of the following applies: in combination with LHRH analog (e.g, Lupron, Trelstar) OR has previous bilateral orchiectomy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner

abiraterone

Coverage Duration	6 months duration
Other Criteria	NA

acitretin

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Pregnant or breastfeeding members, members with severe renal impairment or failure, members with severe hepatic dysfunction.
Required Medical Information	Member must have a diagnosis of severe cutaneous psoriasis including plaque, guttate, erythrodermic, palmar-plantar, and pustular types AND the member has had previous treatment, contraindication, or intolerance to methotrexate or cyclosporine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ACTIMMUNE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Chronic Granulomatous Disease (CGD): The member has chronic granulomatous disease (CGD). The member is using Actimmune to reduce the frequency and severity of infections. Severe Malignant Osteopetrosis: The member has severe malignant osteopetrosis confirmed by biopsy. The member is using Actimmune to delay time to disease progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	NA

acyclovir

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	The member must have a diagnosis of genital herpes OR member has a diagnosis of non-life-threatening mucocutaneous Herpes Simplex Virus (HSV) infection and is immunocompromised. The member has had previous treatment, contraindication, or intolerance with oral acyclovir and one of the following: valacyclovir or famciclovir.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

ADEMPAS

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Chronic Thromboembolic Pulmonary Hypertension (CTEPH). The member must have a diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) AND The member must have CTEPH classified as inoperable or persistent/recurrent after surgical treatment (i.e. pulmonary endarterectomy). Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

AFINITOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV) AND the member experienced intolerance on Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome) AND Afinitor (everolimus) is given as monotherapy or being given in combination with Lenvima (lenvatinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstromâ??s macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstromâ??s Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.
Age Restriction	TSC associated partial onset seizures: Member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) within one year AND The member will use Afinitor (everolimus) in combination with exemestane or fulvestrant (Faslodex). Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND Afinitor Disperz (everolimus tablets for oral solution) is being used as adjunctive therapy.

AFINITOR DISPERZ

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV) AND the member experienced intolerance on Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome) AND Afinitor (everolimus) is given as monotherapy or being given in combination with Lenvima (lenvatinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstromâ??s macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstromâ??s Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.
Age Restriction	TSC associated partial onset seizures: Member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) within one year AND The member will use Afinitor (everolimus) in combination with exemestane or fulvestrant (Faslodex). Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND Afinitor Disperz (everolimus tablets for oral solution) is being used as adjunctive therapy.

AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has experienced a positive clinical response (e.g. sustained decrease in migraine days per month).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth: 3 months. Reauth: Plan Year Duration.
Other Criteria	NA

ALECENSA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression while on Alecensa (alectinib).
Required Medical Information	Non-small Cell Lung Cancer:The member has recurrent or metastatic non-small cell lung cancer AND The member has documented anaplastic lymphoma kinase (ALK)-positive disease AND The member will be using Alecensa (alectinib) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

alosetron

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Should not be initiated in members with constipation OR with anatomic or biochemical abnormalities of the gastrointestinal tract OR Members with a history of chronic or severe constipation or with a history of sequelae from constipation OR History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions OR History of ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state OR Current or history of Crohn's disease or ulcerative colitis OR Active diverticulitis or a history of diverticulitis OR Patients with severe hepatic impairment.
Required Medical Information	The member has a diagnosis of severe diarrhea-predominant irritable bowel syndrome AND has chronic IBS symptoms (lasting 6 months or longer) AND the member has had previous treatment, contraindication, or intolerance to one antidiarrheal agent (e.g. loperamide) and one antispasmodic agent (e.g. dicyclomine). Reauthorization criteria: In addition to the above clinical criteria, the member must have a positive clinical response from alosetron HCl.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ALUNBRIG

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant ALK inhibitors (e.g., Zykadia [certinib], Alecensa [alectinib]). Members experience disease progression on Alunbrig (brigatinib).
Required Medical Information	Non-Small cell lung cancer: The member has a diagnosis of advanced or metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Alunbrig will be given as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

alyq

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ambrisentan

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has a diagnosis of idiopathic pulmonary fibrosis.
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

APTIOM

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use of oxcarbazepine
Required Medical Information	Partial-Onset Seizures. Diagnosis of partial-onset seizures. Prior therapy with, contraindication, or intolerance to at least two other drugs for controlling partial-onset seizures (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Inadequately controlled seizures.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome: The member has a diagnosis of Cryopryin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS). Recurrent Pericarditis: Member has a diagnosis of recurrent pericarditis defined by: presentation of symptoms of acute pericarditis after a symptom-free interval of at least 4 weeks. Deficiency of Interleukin-1 Receptor Antagonist (DIRA) The member has a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA).
Age Restriction	Member must be 12 years of age or older for Familial Cold Autoinflammatory Syndrome, Muckle-Wells Syndrome, and Recurrent Pericarditis indications. Age restriction does not apply to DIRA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

asenapine maleate

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Schizophrenia/Bipolar I Disorder, manic or mixed episodes. The member must be utilizing asenapine for treatment of schizophrenia or bipolar I disorder. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

AUSTEDO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Initial Therapy - TD: The member is utilizing Austedo (deutetrabenazine) for the treatment of tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) OR Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member is utilizing Austedo (deutetrabenazine) for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). AND The provider attests that the risk versus benefit of depression and suicidality has been considered, and the benefits of treatment outweigh the risks. Continuation- TD: The member has a documented improvement or maintenance of symptoms while on Austedo (deutetrabenazine) (e.g. reduction in Abnormal Involuntary Movement Scale [AIMS] score or Dyskinesia Identification System: Condensed User Scale [DISCUS] from baseline) AND the provider attests that the risk versus benefit of depression and suicidality has been considered, and the benefits of treatment outweigh the risks. Initial Therapy - Chorea with HD: Diagnosis of chorea associated with Huntington's disease AND Inadequate symptom control (e.g. no improvement in total maximal chorea [TMC] score, no improvement in overall motor function) on previous treatment with tetrabenazine therapy or intolerance to tetrabenazine AND The provider attests that the risk versus benefit of depression and suicidality has been considered, and the benefits of treatment outweigh the risks. Continuation - Chorea with HD: The member has a documented improvement or maintenance of symptoms (e.g. reduction in total maximal chorea [TMC] score, improvement in overall motor function) with Austedo (deutetrabenazine) AND the provider attests that the risk versus benefit of depression and suicidality has been considered, and the benefits of treatment outweigh the risks.
Age Restriction	Member is 18 years of age or older (Tardive Dyskinesia).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth: 3 months, Reauthorization: Plan Year Duration
Other Criteria	

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review

AYVAKIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Ayvakit (avapritinib).
Required Medical Information	Gastrointestinal Stromal tumor. The member has documented PDGFRA exon 18 mutation-positive unresectable or metastatic gastrointestinal stromal tumor (including PDGFRA D842V) AND Ayvakit (avapritinib) will be given as monotherapy. Advanced systemic mastocytosis: The member has a diagnosis of advanced systemic mastocytosis (AdvSM), including systemic mastocytosis with an associated hematological neoplasm and mast cell leukemia AND Avyakit is not recommended for the treatment of members with AdvSM with platelet counts of less than 50 X 109 /L AND Ayvakit (avapritinib) is administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	

BALVERSA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial carcinoma AND the member has identification of a susceptible FGFR3 or FGFR2 genetic alteration documented in the medical record [e.g., FGFR3 gene mutations (R284C, S249C, G370C, Y373C), FGFR gene fusions (FGFR3-TACC3, FGFR3-BAIAP2L1, FGFR2-BICC1, FGFR2-CASP7) AND the member will be using Balversa (erdafitinib) as a single agent for subsequent therapy after disease progression during or following at least one prior line of platinum-containing systemic chemotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

BENLYSTA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Severe active central nervous system lupus.
Required Medical Information	Systemic Lupus Erythematosus (SLE). The member must have a diagnosis of active systemic lupus erythematosus (SLE).The member must be auto-antibody positive in the absence of any drugs for SLE defined as: ANA titer greater than or equal 1:80 or anti-dsDNA level greater than or equal 30 I/mL. The member must be utilizing Benlysta (belimumab) in combination with standard treatment regimens for SLE which may include: corticosteroids (e.g. prednisone), hydroxychloroquine, azathioprine. Lupus Nephritis: The member must have a diagnosis of active lupus nephritis AND the member must be utilizing Benlysta in combination with standard therapy (e.g. corticosteroids with mycophenolate or cyclophosphamide).
Age Restriction	Lupus Nephritis: The member is 5 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

BETASERON

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

bexarotene

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that are pregnant. Members on concomitant retinoid therapy.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

bosentan

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

BOSULIF

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Bosulif (bosutinib). The member has one of the following mutations: T315I, V299L, G250E, or F317L.
Required Medical Information	Chronic Myelogenous Leukemia. The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The member has a diagnosis of chronic phase CML that has received previous treatment AND Low-, intermediate-, or high-risk score for disease progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

BRAFTOVI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Tafinlar (dabrafenib), or Mekinist (trametinib) OR Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Colorectal Cancer - [Braftovi (encorafenib) requests only]: The member has documented BRAFV600E metastatic metastatic colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month durations or as determined through clinical review
Other Criteria	NA

BRIVIACT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-onset seizures. Member must have a diagnosis of partial-onset seizures. Member has had prior therapy with levetiracetam AND one of the following: topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

BRUKINSA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a BTK inhibitor (e.g. ibrutinib, acalabrutinib, zanabrutinib).
Required Medical Information	Mantle cell lymphoma. The member has a diagnosis of mantle cell lymphoma AND The member has received at least one prior therapy AND The member will be using Brukinsa (zanabrutinib) as monotherapy. Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma (MZL) AND The member is using Brukinsa (zanubrutinib) as second line or subsequent for refractory or progressive disease AND The member has received at least one regimen containing anti-CD20 product (e.g. rituximab product) AND The member has a medical reason as to why Imbruvica (ibrutinib) cannot be started or continued AND The member will be using Brukinsa (zanubrutinib) as monotherapy. Waldenström's Macroglobulinemia: The member has a diagnosis of Waldenström’s macroglobulinemia (WM) AND the member will be using Brukinsa (zanubrutinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	

budesonide

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Mild to moderate active Crohn's disease: The member must have a diagnosis of mild to moderate active Crohn's disease. Autoimmune hepatitis: Member must have a diagnosis of autoimmune hepatitis.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

buprenorphine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with significant respiratory depression. Members with acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment. Members with known or suspected gastrointestinal obstruction, including paralytic ileus.
Required Medical Information	Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment AND has tried at least 1 alternative therapy (e.g. non-opioid analgesics, or immediate-release opioids, or extended-release opioids).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

CABLIVI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Acquired Thrombotic Thrombocytopenic Purpura: Member has a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) AND member has achieved a normalized platelet count following plasma exchange (PEX) in combination with Cablivi (caplacizumab-yhdp) and immunosuppresive therapy (e.g. rituximab) during inpatient treatment of TTP. Reauthorization: member continues to have evidence of ongoing disease (e.g. suppressed or unstable ADAMTS13 levels) AND member is still currently receiving therapy AND member has had 2 or fewer recurrences while actively receiving Cablivi.
Age Restriction	Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months duration
Other Criteria	NA

CABOMETYX

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on cabozantinib.
Required Medical Information	Renal cell carcinoma: The member has advanced renal cell carcinoma AND one of the following applies: the member will be using Cabometyx (cabozanitinib) as monotherapy OR the member will be using Cabometyx (cabozanitinib) in combination with Opdivo (nivolumab) as first line therapy. Hepatocellular carcinoma. The member has a diagnosis of hepatocellular carcinoma AND The member has been previously treated with a first line therapy (e.g., sorafenib) AND Cabometyx (cabozantinib) will be given as monotherapy. Thyroid Cancer: The member has a diagnosis of locally advanced or metastatic differentiated thyroid cancer AND Member has experienced disease progression following prior anti-VEGF targeted therapy AND Member is radioactive iodine refractory or ineligible AND Cabometyx (cabozantinib) will be administered as monotherapy.
Age Restriction	Thyroid Cancer: Member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	

calcipotriene

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Psoriasis: The member must have a diagnosis of plaque psoriasis AND has had previous treatment, contraindication or intolerance with topical triamcinolone 0.5% AND topical betamethasone dipropionate.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

CALQUENCE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression while on or following Calquence (acalabrutinib).
Required Medical Information	Mantle Cell Lymphoma: The member had a diagnosis of mantle cell lymphoma AND the member has received at least one prior therapy AND the member will be using Calquence (acalabrutinib) as monotherapy. Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL): member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression while on or following Calquence (acalabrutinib).
Required Medical Information	Mantle Cell Lymphoma: The member had a diagnosis of mantle cell lymphoma AND the member has received at least one prior therapy AND the member will be using Calquence (acalabrutinib) as monotherapy. Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL): member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review

CAPLYTA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Schizophrenia. The member must have a diagnosis of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Bipolar I or II Disorder (Dipolar Depression): The member must have a diagnosis of bipolar I or II disorder (bipolar depression) AND the member must have documentation of prior therapy, intolerance, or contraindication to quetiapine and at least one of the following: risperidone, olanzapine, ziprasidone, or aripiprazole.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

CAPRELSA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Vandetanib.
Required Medical Information	Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic medullary thyroid cancer AND The member has symptomatic or progressive disease OR the member has a diagnosis of symptomatic iodine refractory follicular carcinoma or Hurthle cell carcinoma or papillary carcinoma AND unresectable recurrent or persistent locoregional disease or metastatic disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has acute or chronic hyperammonemia due to deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS). Acute hyperammonemia due to PAA or MMA deficiency: the member has acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

carglumic acid

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has acute or chronic hyperammonemia due to deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS). Acute hyperammonemia due to PAA or MMA deficiency: the member has acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

CAYSTON

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 75% predicted. Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis. The member must have a diagnosis of cystic fibrosis (CF). The member is colonized with Pseudomonas aeruginosa. The member must have a short or long-acting beta-agonist bronchodilator (e.g. albuterol or formoterol), and will be utilized prior to Cayston.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year duration
Other Criteria	

CERDELGA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concurrent use of a strong or moderate CYP2D6 inhibitor (eg. paroxetine, terbinafine) and a strong or moderate CYP3A inhibitor (eg. ketoconazole, fluconazole) in patients who are EMs or IMs.Concurrent use of a strong CYP3A inhibitor in patients who are IMs or PMs (eg. ketoconazole).
Required Medical Information	Type 1 Gaucher's disease:The member has a diagnosis of type 1 Gaucher's disease AND Member is a CYP2D6 poor metabolizer (PM), extensive metabolizer (EM), or intermediate metabolizer (IM) as confirmed by an FDA-approved genetic test.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

CEREZYME

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Cerezyme (imiglucerase) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Confirmed diagnosis of Type 1 Gaucher disease, resulting in one or more of the following conditions: Anemia, Thrombocytopenia, Bone disease, Hepatomegaly, Splenomegaly.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

CHENODAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	A nonvisualizing gallbladder confirmed by two consecutive single doses of dye OR Radiopaque (calcified) stones OR Pregnancy OR Patients with known hepatocyte dysfunction OR Patients with biliary tract disease including bile ductal abnormalities such as inrahepatic cholestasis, primary biliary cirrhosis, or sclerosing cholangitis OR Patients with gallstone complications or gallbladder disease necessitating surgery due to unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-GI fistula.
Required Medical Information	The member has a diagnosis of radiolucent gallstones in well-opacifying gallbladders AND the member is not a candidate for laparoscopic cholecystectomy AND the member must have had previous treatment with, contraindication, or intolerance to ursodiol.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

CHOLBAM

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects initial review: The member must have a diagnosis of bile acid synthesis disorders (BASDs) due to single enzyme defects confirmed by Fast Atom Bombardment Ionization analysis (FAB-MS) (e.g. 3ß-hydroxy- ?5-C27-steroid oxidoreductase (3ß-HSD)deficiency, ?4-3-oxosteroid 5ß-reductase (AKR1D1) deficiency, cerebrotendinous xanthomatosis (CTX), or 2-[or a-] methylacyl-CoA racemase (AMACR) deficiency). Adjunctive treatment of peroxisomal disorders: The member must have a diagnosis of a peroxisomal disorder (PD) confirmed by Fast Atom Bombardment Ionization analysis (FAB-MS), including: Zellweger Syndrome or Neonatal Adrenoleukodystrophy or Generalized Peroxisomal Disorder or Refsum Disease or Peroxisomal disorder of unknown type) AND 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. Continuation of therapy: The member must show improvement in liver function within 3 months of the start of treatment without complete biliary obstruction: Alanine transaminase (ALT) or aspartate transaminase (AST) values reduced to less than 50 U/L or baseline levels reduced by 80% AND Total bilirubin values reduced to less than or equal to 1 mg/dL.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 3 months. Continuation of Therapy: Plan Year Duration.
Other Criteria	NA

CHORIONIC GONADOTROPIN, HUMAN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.
Required Medical Information	NA
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

CLEOCIN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	plan year
Other Criteria	NA

clobazam

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Lennox-Gastaut Syndrome. Member has diagnosis of seizures associated with LGS.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

clozapine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had prior therapy or intolerance to generic clozapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

COMETRIQ

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Cometriq (cabozantinib). Members on concomitant tyrosine kinase inhibitors.
Required Medical Information	Metastatic Medullary Thyroid Carcinoma. The member has a diagnosis of progressive, metastatic medullary thyroid carcinoma MTC.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	six month duration
Other Criteria	NA

COPAXONE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

COPIKTRA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib, duvelisib).
Required Medical Information	Chronic lymphocytic leukemia. The member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND the member has relapsed or refractory disease AND The member will be using Copiktra (duvelisib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration.
Other Criteria	

CORLANOR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Heart rate maintained exclusively by pacemaker.
Required Medical Information	Heart Failure (Adult Patients): The member must meet ALL of the following criteria: have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 35% AND The member must be in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute AND Documentation of blood pressure greater than or equal to 90/50 mmHg AND Documentation of previous treatment, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker (e.g., carvedilol 50 mg daily, metoprolol 200 mg daily, or bisoprolol 10 mg daily) AND In patients with Severe Hepatic Impairment (Child-Pugh Class C) - Provider attests that the risk versus benefit of severe hypotension has been considered, and the benefits of treatment outweigh the risks. Heart Failure (Pediatric Patients) The member must meet ALL of the following criteria: The member must have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 45% AND The member has been clinically stable for at least 4 weeks and on optimized medical therapy AND The member is in sinus rhythm AND In patients with Severe Hepatic Impairment (Child-Pugh Class C) - Provider attests that the risk versus benefit of severe hypotension has been considered, and the benefits of treatment outweigh the risks AND One of the following: The member is 6 to 12 months of age and has a resting heart rate of greater than or equal to 105 beats per minute OR The member is 1 to less than 3 years of age and has a resting heart rate of greater than or equal to 95 beats per minute OR The member is 3 to less than 5 years of age and has a resting heart rate of greater than or equal to 75 beats per minute OR The member is greater than 5 years of age and has a resting heart rate of greater than or equal to 70 beats per minute.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Reauthorization Criteria (Adult and Pediatric Patients): Member has continued clinical benefit from Corlanor (ivabradine) as defined by maintenance of decreased Heart rate compared to initiation of Corlanor treatment.

COSENTYX

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, and Non-radiographic axial spondyloarthritis: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

COSENTYX (2 SYRINGES)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, and Non-radiographic axial spondyloarthritis: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

COSENTYX PEN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, and Non-radiographic axial spondyloarthritis: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, and Non-radiographic axial spondyloarthritis: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

COTELLIC

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on Cotellic as a single agent.Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda(pembrolizumab), Tafinlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Cotellic. Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Cotellic (cobimetinib) in combination with Zelboraf(vemurafenib).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

CRESEMBA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Invasive Aspergillosis and Invasive Mucormycosis: Member must have diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

CYSTARAN

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystinosis: The member has a diagnosis of cystinosis AND The member is using cysteamine ophthalmic solution in the treatment of corneal cystine crystal accumulation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

dalfampridine

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	History of seizure disorder. Moderate to severe renal impairment (CrCl less 50ml/min).
Required Medical Information	Multiple Sclerosis. Member must have a diagnosis of one of the four types of multiple sclerosis: Relapse Remitting or Primary Progressive or Secondary Progressive or Progressive Relapsing. Patient must be ambulatory. Initial timed 25-foot walk T25W test or another objective measure of gait that provides evidence of significant walking impairment related to multiple sclerosis. Reauthorization Criteria. Documentation of improvement in walking using the T25W test or another objective measure of gait.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Auth: 6 months. Reauth: Plan Year Duration.
Other Criteria	NA

DAURISMO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression while on Daurismo (glasdegib).
Required Medical Information	Acute Myeloid Leukemia. The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND One of the following applies: The member is age 75 years or older OR The member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. severe cardiac disease, baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2, or baseline serum creatinine greater than 1.3 mg/dL) AND The member will be using Daurismo (glasdegib) in combination with low-dose Cytarabine. Acute Myeloid Leukemia - Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member will be using Daurismo (glasdegib) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months) AND Daurismo (glasdegib) has not been administered continuously AND Daurismo (glasdegib) was not stopped due to the development of clinical resistance.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

deferasirox

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Patients on concomitant deferoxamine or deferipone. The member has platelet counts less 50,000.
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.). Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

DIACOMIT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Dravet syndrome: The member has a diagnosis of Dravet syndrome by a specialist (i.e. neurologist or epileptologist) AND The member is refractory on current therapy (e.g experiencing generalized tonicclonic or clonic seizures within the past 28 days) AND The member is taking concomitant clobazam therapy.
Age Restriction	The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

diclofenac sodium

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Actinic Keratosis: The member has a diagnosis of actinic keratosis. The member has trial, intolerance, or contraindication to generic imiquimod 5% cream or topical fluorouracil.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

dihydroergotamine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute treatment of moderate to severe migraine headaches with or without aura AND has had previous treatment, intolerance, or contraindication to two of the following: naproxen tablet, naratriptan tablet, rizatriptan tablet, sumatriptan tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

dimethyl fumarate

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

DOJOLVI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Long-Chain Fatty Acid Oxidation Disorders: The member has a diagnosis of long-chain fatty acid disorders (e.g. Very Long-chain acylCoA Dehydrogenase [VLCAD] deficiency, Carnitine Palmitoyltransferase 2 [CPT2] deficiency, Mitochondrial Trifunctional Protein [TFP] Deficiency, Long-chain 3 hydroxyacylCoA Dehydrogenase [LCHAD] deficiency) AND Genetic and/or molecular testing has been performed to confirm diagnosis (e.g. positive for pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Major Depressive Disorder, Generalized Anxiety Disorder, or Diabetic Peripheral Neuropathic Pain: The member has a diagnosis of Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), or Diabetic Peripheral Neuropathic Pain (DPNP). The member has prior therapy, intolerance, or contraindication with venlafaxine (IR or ER) AND duloxetine. Chronic Musculoskeletal Pain, Fibromyalgia: The member has a diagnosis of Chronic Musculoskeletal Pain or Fibromyalgia (FM). The member has prior therapy, intolerance, or contraindication with duloxetine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

DUAVEE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Abnormal uterine bleeding. Known or past history of breast cancer. Active or past history of venous thromboembolism (e.g. pulmonary embolism, deep vein thrombosis). Known estrogen-dependent neoplasia. Active or past history of arterial thromboembolism (e.g. stroke and myocardial infarction). Duavee should not be used in members who are pregnant or lactating. Known hepatic impairment or liver disease. Known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders. Concurrent use with estrogens, progestins, or estrogen agonists/antagonists.
Required Medical Information	Treatment of moderate to severe vasomotor symptoms associated with menopause:Diagnosis of moderate to severe vasomotor symptoms associated with menopause AND The member must have had previous treatment, intolerance or contraindication to a SSRI [e.g. citalopram, fluoxetine, paroxetine hydrochloride] or venlafaxine. Prevention of osteoporosis: For the prevention of osteoporosis in a member who is postmenopausal AND the member must have had previous treatment, intolerance, or contraindication to either alendronate or Evista (raloxifene).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

EGRIFTA SV

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Egrifta (tesamorelin) therapy is not considered medically necessary for members with the following concomitant conditions: The member must not have an active malignancy. Pregnancy.
Required Medical Information	HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	

ELELYSO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Gaucher Disease. The member has a confirmed diagnosis of Type 1 Gaucher disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	NA

EMGALITY PEN

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has experienced a positive clinical response (e.g. sustained decrease in migraine days per month).
Age Restriction	The member is 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth: 3 months. Reauth: Plan Year Duration
Other Criteria	NA

EMGALITY SYRINGE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Episodic or Chronic Migraine. Initial therapy: The member has documented history of greater than or equal to 4 migraine days per month AND the member has been unable to achieve at least a 2 day reduction in migraine headache days per month after previous treatment (of at least 2 months) with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol. Reauthorization: The member has experienced a positive clinical response (e.g. sustained decrease in migraine days per month).
Age Restriction	The member is 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth: 3 months. Reauth: Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Pheochromocytoma.
Required Medical Information	Major Depressive Disorder: The member is at least 12 years of age. The member is an adult with a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D). The member has had prior therapy, intolerance, or contraindication with a generic SSRI (e.g. citalopram, fluoxetine, paroxetine, or sertraline), generic SNRI (e.g. venlafaxine or duloxetine), a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) OR mirtazapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ENBREL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ENBREL MINI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ENBREL SURECLICK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis. The member has prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of chronic moderate to severe plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs.
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ENVARSUS XR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Member must have had a kidney transplant AND Must be using Envarsus XR for prophylaxis of organ rejection AND Must be using in combination with other immunosuppressants.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

EPCLUSA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C Virus Genotypes: The member must have a diagnosis of chronic hepatitis C (HCV). Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	

EPIDIOLEX

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Dravet Syndrome: The member has a diagnosis of seizures associated with Dravet Syndrome AND Epidiolex is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has had prior therapy with, contraindication, or intolerance to at least one other drug used for the treatment of Dravet Syndrome (e.g. clobazam, valproic acid, topiramate). Lennox-Gastaut: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Epidiolex is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has had prior therapy with, contraindication, or intolerance to at least one other drug used for the reatment of Lennox-Gastaut syndrome (e.g. topiramate, lamotrigine). Tuberous Sclerosis Complex: The member has a diagnosis of seizures associated with Tuberous Sclerosis Complex. Reauthorization (all indications): The member has experienced an improvement in seizure frequency from documented pre-treatment baseline.
Age Restriction	The member is at least 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

EPRONTIA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prophylaxis: Member is using for prophylaxis of migraine headache AND has had previous treatment with or intolerance to immediate release topiramate tablet or capsule AND has had previous treatment, intolerance, or contraindication with propranolol or timolol. Epilepsy Adjunctive Therapy: Member has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Concomitant use of at least one antiepileptic medication (e.g. lamotrigine, carbamazepine, levetiracetam) AND Has had previous treatment with or intolerance to immediate release topiramate tablet or capsule AND Has unsuccessful control of seizures as determined by treating physician. Epilepsy Monotherapy: Member must have diagnosis of partial-onset seizures or primary generalized tonic-clonic seizures AND Member has had previous treatment with or intolerance to immediate release topiramate tablet or capsule AND Has unsuccessful control of seizures as determined by treating physician.
Age Restriction	Migraine Prophylaxis: Member must be 12 years of age or older. Epilepsy indications: Member must be 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

ergotamine-caffeine

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Acute Migraine. Acute treatment of migraines AND has had previous treatment, intolerance, or contraindication to one of the following: naratriptan, rizatriptan, sumatriptan.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ERIVEDGE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Erivedge (vismodegib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Erivedge (vismodegib). Members that are using Erivedge (vismodegib) as neoadjuvant therapy.
Required Medical Information	Advanced Basal Cell Carcinoma.The member has a diagnosis of metastatic basal cell carcinoma OR The member has a diagnosis of locally advanced basal cell carcinoma AND one of the following applies: The member has disease that has recurred following surgery OR the member is not a candidate for surgery AND radiation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA

ERLEADA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Erleada (apalutamide). Concoitant use with an androgen receptor inhibitor or androgen synthesis inhibitor (e.g., enzulutamide, abiraterone, nilutamide, flutamide, bicalutamide) due to lack of evidence supporting efficacy and safety.
Required Medical Information	Prostate Cancer (non-metastatic castration resistant): The member has a diagnosis of non-metastatic castration resistant prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog). Prostate Cancer (metastatic castration-sensitive): The member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

erlotinib

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.
Required Medical Information	Pancreatic Cancer: The member has a diagnosis of unresectable, locally advanced or metastatic pancreatic cancer. AND erlotinib is being used in combination with Gemzar (gemcitabine).Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC AND all of the following apply: The member has known documented activated EGFR mutation (such as E19del in exon 19 or L858R in exon 21). Renal Cell Carcinoma: Diagnosis of relapsed or unresectable stage IV renal cell carcinoma with non clear histology and erlotinib will be used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

ESBRIET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF): The member meets ALL of the following criteria: Diagnosis of idiopathic pulmonary fibrosis by exclusion of clinically significant environmental exposure or explanation for pulmonary fibrosis or interstitial lung disease (e.g. drugs, asbestos, beryllium, radiation, and domestic birds, radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, or cancer). AND Documentation of Pulmonary Fibrosis by one of the following: computed tomography (CT) scan is indicative of usual interstitial pneumonia (UIP) OR a surgical lung biopsy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

EULEXIN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prostate Cancer: the member has a diagnosis of prostate cancer AND the member will be using Eulexin (flutamide) alone or in combination therapy with a luteinizing hormone-releasing hormone (LHRH) analog.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

everolimus (antineoplastic)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV) AND the member experienced intolerance on Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome) AND Afinitor (everolimus) is given as monotherapy or being given in combination with Lenvima (lenvatinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstromâ??s macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstromâ??s Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.
Age Restriction	TSC associated partial onset seizures: Member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

everolimus (antineoplastic)

Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) within one year AND The member will use Afinitor (everolimus) in combination with exemestane or fulvestrant (Faslodex). Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND Afinitor Disperz (everolimus tablets for oral solution) is being used as adjunctive therapy.

EXKIVITY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Exkivity (mobocertinib).
Required Medical Information	Metastatic Non-Small Cell Lung Cancer (NSCLC): The member has locally advanced or metastatic NSCLC AND The NSCLC has documented EGFR exon 20 insertion mutation AND The member has experienced disease progression on platinum based therapy AND Exkivity (mobocertinib) is administered as single agent as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

FANAPT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Schizophrenia. The member must be utilizing it for treatment of schizophrenia.The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year duration.
Other Criteria	NA

FARYDAK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression on Farydak (panobinstat).
Required Medical Information	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND The member has received at least two prior regimens, including both bortezomib and an immunomodulatory drug (thalidomide, lenalidomide, pomalidomide) AND one of the following applies: The member will be using Farydak (panobinostat) in combination with bortezomib and dexamethasone OR the member will be using Farydak (panobinostat) in combination with Kyprolis (carfilzomib) OR the member will be using Farydak (panobinostat) in combination with Revlimid (lenalidomide) and dexamethasone.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	6 months duration.
Other Criteria	NA

fentanyl citrate

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Treatment of acute or post-operative pain.
Required Medical Information	The member is currently diagnosed with cancer. Fentanyl citrate is required to manage breakthrough cancer pain. The member is currently taking opioid therapy and is opioid tolerant. Tolerance is defined as any of the following: greater than or equal 60 mg oral morphine/day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, 60 mg oral hydrocodone/day for greater than or equal 1 week, An equianalgesic dose of another opioid for greater than or equal 1 week.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

FETZIMA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Major depressive disorder: The member must be utilizing Fetzima for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a serotonin and norepinephrine reuptake inhibitor (SNRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

fingolimod

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

FINTEPLA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Treatment with a monoamine oxidase inhibitor within the last 14 days.
Required Medical Information	Dravet Syndrome: The member has a diagnosis of Dravet syndrome AND the member is experiencing seizures associated with Dravet syndrome on current therapy at baseline AND The member has had previous treatment with valproic acid AND fenfluramine will be taken concomitantly with another anti-epileptic supported for the treatment of seizures associated with Dravet Syndrome (e.g. valproic acid, clobazam, topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of Lennox-Gastaut Syndrome AND the member has had prior therapy with, contraindication, or intolerance to at least two antiepileptics supported for the treatment of Lennox-Gastaut syndrome (e.g. topiramate, lamotrigine) AND Fintepla (fenfluramine) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist).
Age Restriction	The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

FIRDAPSE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of seizures (not to be inferred from pharmacy claims)
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS). The member has a confirmed diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) by a specialist (e.g. neurologist) AND The diagnosis is supported by results from a clinical evaluation (e.g. electromyography or the presence of autoantibodies directed against VGCC {voltagegated calcium channels}).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

FIRMAGON

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

formoterol fumarate

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Asthma, in the absence of concurrent medication containing inhaled corticosteroid and comorbid COPD diagnosis.
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD).Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema, requiring maintenance treatment of bronchoconstriction.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

FORTEO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	The member is postmenopausal with a diagnosis of osteoporosis. The member is at high risk for osteoporotic fracture as evident by one of the following: The member has a history of osteoporotic fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate, ibandronate, pamidronate). The member is taking sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone). The member is at high risk for osteoporotic fracture as evident by one of the following: The member has a history of osteoporotic fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate, ibrandronate, pamidronate). The member has a diagnosis of primary or hypogonadal osteoporosis, who is at high risk for fracture, defined as history of osteoporotic fracture, or who have multiple risk factors for fracture.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan year duration.
Other Criteria	NA

FOTIVDA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on Fotivda (tivozanib).
Required Medical Information	Relapsed or refractory advanced renal cell carcinoma: The member has a diagnosis of relapsed or refractory advanced renal cell carcinoma AND The member has received two prior systemic therapies (e.g., immuno-oncology checkpoint inhibitors, cabozantinib, axitinib) AND Fotivda (tivozanib) is given as a single agent for subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgastrim-sndz or filgastrim-aafi), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose). Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis. The member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than 2.0 mg/dL) OR Renal dysfunction (creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.

FYCOMPA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Partial-onset seizures: Inadequately controlled partial-onset seizures. Adjunctive treatment for members with generalized tonic-clonic seizures: Inadequately controlled partial-onset seizures and concomitant use of at least one antiepileptic medication.
Age Restriction	Adjunctive treatment for generalized tonic-clonic seizures: Age 12 years and older. Partial-onset seizures: age 4 years and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

GAMUNEX-C

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/µL),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/µL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/µL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Infections in Low-Birthweight Neonates.Prophylaxis and treatment of infections in high-risk, preterm, low-birth weight members.Diagnosed with staphylococcal / streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, an undrainable focus is present, or has persistent oliguria with pulmonary edema. Diagnosed with autoimmune neutropenia and G-CSF therapy is not appropriate. Autoimmune Hemolytic Anemia. Is refractory to corticosteroid therapy and splenectomy. Myasthenia Gravis. Is experiencing acute myasthenic crisis with decompensation.Other treatments have been unsuccessful (e.g., corticosteroids, azathioprine, cyclosporine, and cyclophosphamide). Guillain-Barre Syndrome. Is severely affected by the disease and requires an aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed with multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed with relapsing-remitting multiple sclerosis and has failed conventional therapy (Betaseron, Avonex, etc.).Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs, OR There is muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambart-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has not responded to diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate is diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections. Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisista,etc. Has tried and failed conventional therapy or has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.Stiff-Person Syndrome. Other interventions (diazepam) have been unsuccessful. Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or in members with hemolytic anemia/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.

GATTEX 30-VIAL

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 Month Duration
Other Criteria	NA

GATTEX ONE-VIAL

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 Month Duration
Other Criteria	NA

GAVRETO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on RET inhibitors (e.g., pralsetinib, selpercatinib).
Required Medical Information	Non-small cell lung cancer: The member has a diagnosis of metastatic non-small lung cancer AND the disease is documented as RET fusion positive AND Gavreto (pralsetinib) is being used as monotherapy. Medullary Thyroid cancer: The member has a diagnosis of metastatic or advanced medullary thyroid cancer AND The disease is documented RET mutant AND Gavreto (pralsetinib) is being used as monotherapy for systemic therapy. Thyroid cancer: The member has a diagnosis of metastatic or advanced thyroid cancer AND The disease is documented RET fusion positive AND The disease is radioactive iodine refractory AND Gavreto (pralsetinib) is being used as monotherapy for systemic therapy.
Age Restriction	Thyroid Cancer and Medullary Thyroid Cancer: The member is 12 years of age and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

GILENYA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

GILOTRIF

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following apply: The member has a documented non-resistant epidermal growth factor receptor (EGFR) mutation (sensitizing EGFR mutation e.g., exon 19 deletion, L861Q, S768I, G719X, L858R) AND The member is using Gilotrif (afatinib) as monotherapy (without concomitant chemotherapy) OR squamous cell histology after disease progression on platinum containing chemotherapy and is using Gilotrif (afatinib) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

glatiramer

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

glatopa

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

HAEGARDA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use for acute treatment of HAE attack. Evidence of autoantibodies against the C1INH protein. Evidence of underlying lymphoproliferative, malignant, or autoimmune disorder that causes angioedema attacks. Use in combination with other agents approved for prophylactic treatment of HAE attack (e.g. Cinryze).
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Low evidence of C4 level (i.e. C4 level below lower limit of normal laboratory reference range) AND Low C1 inhibitor (C1INH) antigenic level (i.e. C1INH level below lower limit of normal laboratory reference range) OR Low C1INH functional level (i.e. functional C1INH less than 50% or below lower limit of normal laboratory reference range) OR Known HAE-causing C1INH mutation. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level. The member must be using Haegarda for prophylaxis to prevent attacks of HAE.
Age Restriction	The member must be 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

HARVONI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors, polymerase inhibitors, NS5A inhibitors).
Required Medical Information	Chronic Hepatitis C: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotypes 1a,1b,4,5 and 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C - GT1 treatment naive without cirrhosis and HCV RNA under 6 million will be approved for 8 weeks. Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant, Must must have experienced recurrent HCV infection post-transplant in the allograft liver, Member must be at least 18 years of age, Member must have document genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis, Member must be at least 18 years of age, Member must have genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	

HETLIOZ

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz for the treatment of Non-24-Hour Sleep-Wake Disorder AND member has diagnosis of total blindness (i.e no light perception) in both eyes. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS and documented evidence of nighttime sleep disturbances associated with SMS.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

HETLIOZ LQ

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz for the treatment of Non-24-Hour Sleep-Wake Disorder AND member has diagnosis of total blindness (i.e no light perception) in both eyes. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS and documented evidence of nighttime sleep disturbances associated with SMS.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA PEN CROHNS-UC-HS START

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA(CF) PEDI CROHNS STARTER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) PEDI CROHNS STARTER

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA(CF) PEN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA(CF) PEN CROHNS-UC-HS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA(CF) PEN PEDIATRIC UC

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis. Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide) or contraindication with all DMARDs. Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments.
Age Restriction	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis. The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis or Uveitis. Must be six years or older for Crohns Disease. Must be 12 years or older for Hidradenitis Suppurativa. Must be 5 years or older for Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylprednisolone) OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine). Crohn's Disease: The member must have moderately to severely active Crohn's disease. The member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g.azathioprine, 6-mercaptopurine, methotrexate). Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

HYFTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Facial Angiofibroma: the member must meet all of the following criteria: diagnosis of tuberous sclerosis complex (TSC), experiencing greater than or equal to three facial angiofibromas, and is not receiving systemic mTOR inhibitor therapy (e.g. everolimus).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

IBRANCE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is on concomitant abemaciclib or ribociclib. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., ribociclib, abemaciclib).
Required Medical Information	Breast Cancer:The member has a diagnosis of estrogen receptor-positive and human epidermal growth factor receptor 2-negative breast cancer AND one of the following applies: The member will be using Ibrance in combination with an aromatase inhibitor (e.g., letrozole) as initial endocrine-based therapy for their recurrent disease OR The member will be taking Ibrance (palbociclib) in combination with an aromatase inhibitor (e.g., letrozole) as initial endocrine based therapy for their metastatic disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their recurrent disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their metastatic disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	6 months duration.
Other Criteria	NA

icatibant

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use for prophylaxis of HAE attack. Evidence of autoantibodies against the C1INH protein. Evidence of underlying lymphoproliferative, malignant, or autoimmune disorder that causes angioedema attacks. Use in combination with other agents approved for acute treatment of HAE attack (e.g. Berinert, Kalbitor, Ruconest).
Required Medical Information	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Low evidence of C4 level (i.e. C4 level below lower limit of normal laboratory reference range) AND Low C1 inhibitor (i.e. C1INH level below lower limit of normal laboratory reference range) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (i.e. functional C1INH less than 50% or below lower limit of normal laboratory reference range) OR Known HAE-causing C1INH mutation. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level. The member is using icatibant for treatment of acute attacks of HAE.
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ICLUSIG

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Iclusig (ponatinib). Members on concomitant tyrosine kinase inhibitors.
Required Medical Information	Chronic Myeloid Leukemia (chronic phase):The member has a diagnosis of chronic phase chronic myeloid leukemia (CML) AND one of the following apply: The member has an intolerance, resistance, or contraindication to at least two available tyrosine kinase inhibitors indicated for the treatment of CML OR The member has a documented T315I mutation. Chronic Myeloid Leukemia (accelerated or blast phase): The member has a diagnosis of accelerated or blast phase chronic myeloid leukemia (CML) AND one of the following apply: There are no other kinase inhibitors indicated OR the member has a documented T315I mutation. Acute Lymphoblastic Leukemia: The member has a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) AND one of the following apply: There are no other kinase inhibitors indicated OR The member has a documented T315I mutation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

IDHIFA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has experienced disease progression while on or following Idhifa(enasidenib)
Required Medical Information	Acute Myeloid Leukemia – Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH2 mutation AND One of the following applies: The member will be using Idhifa (enasidenib) as monotherapy OR the member will be using Idhifa (enasidenib) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia – Newly diagnosed: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has newly diagnosed disease AND the member is not a candidate for intensive induction therapy due to comorbidities AND the member has a documented IDH2 mutation AND the member will be using Idhifa (enasidenib) as monotherapy.
Age Restriction	The member is 60 years of age or older for newly diagnosed AML.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	NA

imatinib

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Patients on concomitant tyrosine kinase inhibitors. Patients that have experienced disease progression while on imatinib.
Required Medical Information	The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis. Acute lymphoid leukemia (ALL).The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis of Dermatofibrosacrome protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement.(ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis of unresectable melanoma with activating mutation of C-kit. Imatinib will be used as single agent in subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy.Acute Lymphoid Luekemia (ALL). The member is newly diagnosed with Ph+ ALL AND the member will be using imatinib in combination with chemotherapy.

IMBRUVICA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Imbruvica (ibrutinib).
Required Medical Information	Mantle Cell Lymphoma: The member has a diagnosis of Mantle Cell Lymphoma (MCL) AND The member has received at least one prior therapy for the treatment of MCL AND The member is using Imbruvica as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Waldenstrom's Macroglobulinemia:The member has a diagnosis of Waldenstrom’s macroglobulinemia AND The member is using Imbruvica (ibrutinib) as monotherapy or in combination with a rituximab product. Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma AND The member is using Imbruvica (ibrutinib) as second line or subsequent for refractory or progressive disease AND The member is using Imbruvica (ibrutinib) as monotherapy. Chronic Graft Versus Host Disease (adult): The member has a diagnosis of chronic graft versus host disease (cGVHD) AND The member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g. corticosteroids). Chronic Graft Versus Host Disease (pediatric): The member has a diagnosis of chronic graft versus host disease (cGVHD) AND The member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g. corticosteroids).
Age Restriction	pediatric cGVHD: Member age is 1 year or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

INCRELEX

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The bone epiphyses are closed.
Required Medical Information	Member has a diagnosis of GH gene deletion with development of neutralizing antibodies to GH OR The patient has a diagnosis of severe primary IGF-1 deficiency defined by:height standard deviation score below or equal -3.0 and basal IGF-1 standard deviation score below or equal -3.0 and normal or elevated growth hormone.
Age Restriction	The patient is 2 years or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

INLYTA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Inlyta (axitinib).
Required Medical Information	Renal Cell Carcinoma: The member has a diagnosis of advanced renal cell carcinoma AND Inlyta will be given as one of the following: monotherapy AND the member has a medical reason as to why Cabometyx (cabozantinib) can not be initiated or continued OR in combination with Keytruda or Bavencio as first-line therapy. Advanced Thyroid Carcinoma: The member has a diagnosis of advanced/metastatic follicular carcinoma, Hürthle cell carcinoma, or papillary carcinoma and clinical trials are not available or appropriate AND The member has disease that is not responsive to radio-iodine treatment.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA

INQOVI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).
Required Medical Information	Myelodysplastic Syndromes - Chronic Myelomonocytic Leukemia: The member has a diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo or secondary MDS OR chronic myelomonocytic leukemia (CMML) AND the member will be using Inqovi (decitabine and cedazuridine) as a single agent.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

INREBIC

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Inrebic (fedratinib).
Required Medical Information	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-2 risk disease OR High-risk disease AND the member will be using Inrebic (fedratinib) as monotherapy AND The member has a medical reason as to why Jakafi (ruxolitinib) cannot be used. Reauthorization criteria: Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement) AND physician attestation that the member has not experienced unacceptable toxicities.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth: 6 months duration. Reauthorization: 6 months Duration.
Other Criteria	NA

INTRON A

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Chronic Hepatitis C. Diagnosis of chronic hepatitis C with compensated liver disease (without jaundice, ascites, active gastrointestinal bleeding, encephalopathy). Documentation of quantitative HCV RNA (viral load). For members 18 years of age older: For treatment naïve members with Hepatitis C, the member must first consider pegylated products (Pegasys or Peg-Intron plus ribavirin) or have a contraindication or other clinical circumstance preventing them from using before the member will be eligible to receive Intron A. For members 3 – 17 years of age: Intron A must be used in combination with ribavirin. Chronic Hepatitis B: Diagnosis of chronic HBeAG-positive hepatitis B with compensated liver. Must have ALT greater than 2x the upper limit of normal and have HBV DNA greater than 20,000 IU/ml. Hairy Cell Leukemia. Diagnosis of hairy cell leukemia. Malignant Melanoma. Diagnosis of malignant melanoma and utilizing Intron A as an adjuvant therapy to surgical treatment. Follicular Non-Hodgkin's Lymphoma. Diagnosis of follicular non-Hodgkin's lymphoma.Must be utilizing Intron A in conjunction with anthracycline-containing combination chemotherapy. Condylomata Acuminata. Diagnosis of condylomata acuminata involving external surfaces of the genital and perianal areas. AIDS-Related Kaposi's Sarcoma. Diagnosis of AIDS-related Kaposi's sarcoma.
Age Restriction	Chronic Hep C must 3 years or older. Must be 18 years or older for Hairy Cell Leukemia, Malignant Melanoma, Follicular Non-Hodkins Lymphoma, Condylomata Acuminata, AIDS-related Kaposi¿s Sacroma. 1 year or older for Chronic Hep B.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	HepC:24months, Melanoma,lymphoma:PlanYear,leukemia,HepB:6 months,Condylomata:3weeks,Kaposis:4months
Other Criteria	NA

IRESSA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the following applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Iressa (gefitinib) as monotherapy (without concomitant chemotherapy).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

JAKAFI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Jakafi (ruxolitinib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Jakafi (ruxolitinib).Members on concomitant tyrosine kinase inhibitors or immunomodulatory medications (example: Revlimid/lenalidomide)
Required Medical Information	Myelofibrosis.The member has a documented diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis AND The member has one of the following risk categories, as defined by International Prognostic Scoring System (IPSS): Symptomatic low risk disease OR Symptomatic intermediate-1 risk disease OR Intermediate-2 risk disease OR High risk disease. The member will be using Jakafi (ruxolitinib) as monotherapy (excludes medically necessary supportive agents). Polycythemia Vera: The member has a diagnosis of polycythemia vera AND The member has not achieved treatment goals, has an intolerance, or contraindication to hydroxyurea. Acute Graft Versus Host Disease: The member has a diagnosis of steroid-refractory acute graft versus host disease. Reauthorization criteria. Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement, hematocrit control) AND Physician attestation that the member has not experienced unacceptable toxicities. Chronic Graft Versus Host Disease (cGVHD): The member has a diagnosis of chronic graft-versus-host disease (cGVHD) AND the member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g., corticosteroids). Reauthorization criteria. Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement, hematocrit control) AND Physician attestation that the member has not experienced unacceptable toxicities.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Authorization: Plan Year Duration. Reauthorization: Plan Year Duration.
Other Criteria	

javygtor

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Initial: The member has a diagnosis of PKU. Reauth - The member has tetrahydobiopterin -(BH4) responsive PKU defined by: The member has achieved a greater than or equal to a 20% reduction in blood phenylalanine concentration from pre-treatment baseline OR the member has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescriber.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	First approval: three months. if response is positive extended for plan year duration.
Other Criteria	NA

KALYDECO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystic Fibrosis: The member has a diagnosis of Cystic Fibrosis. The member has a documentation of one mutation in the CFTR gene that is responsive to ivacaftor based on clinical literature and/or in vitro assay data.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

KERENDIA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic kidney disease associated with type 2 diabetes: The member has a diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D) AND The member has serum potassium less than or equal to 5.0 mEq/L upon initiation of therapy AND The member is currently receiving, unless contraindicated or intolerant, the maximally tolerated dose of: Either an angiotensin-converting enzyme inhibitor (e.g. Lisinopril) OR an angiotensin receptor blocker (e.g. losartan).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

ketoconazole

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Systemic Fungal Infection: member has a diagnosis of a systemic fungal infection (i.e., blastomycosis, coccidioidomycosis, histoplasmosis, paracoccidioidomycosis, chromomycosis). Prophylaxis - Transplanted Organ Rejection: member has a transplanted organ AND member will concurrently receive immunuosuppresant therapy with cyclosporine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

KISQALI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member is on concomitant palbociclib or abemaciclib. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib).
Required Medical Information	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) and Verzenio (abemaciclib) cannot be started or continued as initial endocrine based therapy OR The member will be using Kisqali (ribociclib) in combination with aromatase inhibitor (e.g.,letrozole) as initial endocrine-based therapy for their metastatic disease AND The member is pre/peri menopausal and taking LHRH agonist (eg, leuprolide) concomitantly or treated with ovarian ablation. Breast Cancer- Combination with Faslodex (fulvestrant). The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer and one of the following applies: The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as initial endocrine based therapy AND The member is post-menopausal OR the member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as subsequent therapy AND The member has a medical reason as to why Ibrance (palbociclib) AND Verzenio (abemaciclib) cannot be started or continued as subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member is on concomitant palbociclib or abemaciclib. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib).
Required Medical Information	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) and Verzenio (abemaciclib) cannot be started or continued as initial endocrine based therapy OR The member will be using Kisqali (ribociclib) in combination with aromatase inhibitor (e.g.,letrozole) as initial endocrine-based therapy for their metastatic disease AND The member is pre/peri menopausal and taking LHRH agonist (eg, leuprolide) concomitantly or treated with ovarian ablation. Breast Cancer- Combination with Faslodex (fulvestrant). The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer and one of the following applies: The member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as initial endocrine based therapy AND The member is post-menopausal OR the member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant) as subsequent therapy AND The member has a medical reason as to why Ibrance (palbociclib) AND Verzenio (abemaciclib) cannot be started or continued as subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

KORLYM

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Pregnancy. Members with a history of unexplained vaginal bleeding. Members with endometrial hyperplasia with atypia or endometrial carcinoma. Concurrent long-term corticosteroid use.
Required Medical Information	Hyperglycemia secondary to hypercortisolism. Diagnosis of endogenous Cushing's syndrome. AND Type 2 diabetes mellitus or glucose intolerance. AND Failed surgery or are not candidates for surgery.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

KOSELUGO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experienced disease progression on Koselugo (selumetinib)
Required Medical Information	Neurofibromatosis type 1: The member has a diagnosis of neurofibromatosis type 1 which is symptomatic, inoperable plexiform neurofibromas and Koselugo (selumetinib) is given as a monotherapy
Age Restriction	The member is 2 years of age up to 18 years of age (labeled for use in pediatric patients only).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

KYNMOBI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Parkinson's "off" episodes: The member has a diagnosis of Parkinson's disease AND is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Kynmobi AND is experiencing breakthrough "off" periods related to their Parkinson's disease despite optimized therapy AND has had previous treatment, contraindication, or intolerance to at least one of the following: A dopamine agonist (e.g. ropinirole, pramipexole) OR a COMT inhibitor (e.g. entacapone) OR a MAO-B inhibitor (e.g. selegiline).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

lanreotide

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For generic lanreotide requests: member has had prior therapy with or intolerance to brand Somatuline Depot AND meets clinical criteria. Diagnosis of acromegaly. The patient has a diagnosis of acromegaly. The patient has had an inadequate response to or cannot be treated with surgical resection OR The patient has had an inadequate response to or cannot be treated with radiation therapy. Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Carcinoid Syndrome: The member has a diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

LATUDA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Diagnosis of Schizophrenia or Schizoaffective Disorder: The member must have prior therapy, intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Diagnosis of Bipolar I Disorder (Bipolar Depression): The member must have documentation of prior therapy, intolerance, or contraindication to quetiapine.
Age Restriction	For diagnosis of Schizophrenia or schizoaffective disorder, the member must be 13 years of age or older. For diagnosis of Bipolar I Disorder (Bipolar Depression), the member must be 10 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ledipasvir-sofosbuvir

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors, polymerase inhibitors, NS5A inhibitors).
Required Medical Information	Chronic Hepatitis C: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotypes 1a,1b,4,5 and 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C - GT1 treatment naive without cirrhosis and HCV RNA under 6 million will be approved for 8 weeks. Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant, Must must have experienced recurrent HCV infection post-transplant in the allograft liver, Member must be at least 18 years of age, Member must have document genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis, Member must be at least 18 years of age, Member must have genotype 1, 4, 5 or 6 infection, Member must be tested for the presence of HBV by screening for surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	

lenalidomide

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant Thalomid (thalidomide) or Pomalyst (pomalidomide).Members that have experienced disease progression while on Revlimid (lenalidomide).
Required Medical Information	Myelodysplastic Syndromes (MDS) with 5Q deletion. The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has a documented deletion 5q chromosomal abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has no documented 5q deletion abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Multiple Myeloma. Diagnosis of active Multiple Myeloma or Systemic Light Chain Amyloidosis. Primary induction OR for relapsed/refractory disease, Revlimid (lenalidomide) therapy should be utilized in conjunction with dexamethasone if no contraindication. As maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation. For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression/treatment failure. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL). For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

lenalidomide

Other Criteria	Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease AND The member will be using for third line or subsequent systemic therapy. Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], primary cutaneous B-cell lymphoma, marginal zone lymphoma, or mantle cell lymphoma AND The member has relapsed or refractory disease OR The member has a diagnosis of follicular lymphoma AND The member will use as first line therapy or for relapsed or refractory disease.

LENVIMA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Lenvima (lenvatinib).
Required Medical Information	Thyroid Cancer:The member has a diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (i.e. papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma) AND The tumors are not responsive to radio-iodine treatment AND Lenvima (lenvatinib) will be used as monotherapy. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma AND the member is using in combination with Afinitor (everolimus) AND the member has experienced intolerance on Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Hepatocelluar Carcinoma: The member has a diagnosis of unresectable carcinoma AND Lenvima (lenvatinib) will be given as a single agent as first line therapy. Endometrial cancer: The member has a diagnosis of metastatic or recurrent endometrial cancer AND The disease is not MSI-H or dMMR AND The member is not a candidate for surgery or radiation AND The member has experienced disease progression on prior systemic therapy AND Lenvima (levantinib) will be given in combination with Keytruda (pembrolizumab) as subsequent therapy. Renal cell carcinoma- first line therapy: The member has a diagnosis of advanced renal cell carcinoma AND Lenvima (levatinib) will be given in combination with Keytruda (pembrolizumab) as first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

leuprolide (3 month)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

lidocaine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia. The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy. The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member must have a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

LONSURF

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Lonsurf.
Required Medical Information	Metastatic Colorectal Cancer:The member has a diagnosis of metastatic colorectal cancer AND The member is using Lonsurf as monotherapy AND The member has experienced disease progression, intolerance, or contraindication with ALL of the following therapies: fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine),oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF therapy (e.g. bevacizumab, ziv-aflibercept) AND If the member is RAS wild-type: the member has experienced disease progression,intolerance, or contraindication with anti-EGFR therapy (e.g. cetuximab or panitumumab). Gastric cancer. The member has recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma AND The member has experienced disease progression on or after two lines of therapy including fluoropyrimidine, platinum (e.g., cisplatin), either taxane (e.g., paclitaxel) or irinotecan and if appropriate, HER2/neu-targeted therapy (e.g., trastuzumab) AND Lonsurf will be given subsequent therapy as a single agent.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	NA

LORBRENA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant ALK inhibitors (e.g., Zykadia [certinib], Alecensa [alectinib]). Members experience disease progression on Lorbrena (lorlatinib).
Required Medical Information	Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Lorbrena (lorlatinib) will be given as monotherapy AND one of the following applies in the metastatic setting: as first line therapy AND the member has a medical reason as to why Alecensa (alectinib) or Alunbrig (brigatinib) cannot be initiated or continued as first line therapy OR Subsequent therapy after disease progression on prior ALK inhibitor (e.g., alectinib, brigatinib). Non- small cell lung cancer [ROS-1 rearrangement]: The member has a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer AND The disease is positive for documented ROS-1 rearrangement and following disease progression on Xalkori (crizotinib), Rozlytrek (entrectinib), or Zykadia (ceritinib) AND Lorbrena (lorlatinib) will be given as a single agent as subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

LUMAKRAS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on Lumakras.
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic NSCLC AND The NSCLC has documented KRAS G12C mutation AND The member has experienced disease progression on one prior therapy AND Lumakras (sotorasib) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

LUPRON DEPOT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LUPRON DEPOT (3 MONTH)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LUPRON DEPOT (4 MONTH)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LUPRON DEPOT-PED

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LUPRON DEPOT-PED (3 MONTH)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents.
Required Medical Information	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	NA

LYBALVI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use of opioids. Episode of acute opioid withdrawal.
Required Medical Information	Schizophrenia or Bipolar I Disorder (Bipolar Depression): The member must have a diagnosis of schizophrenia or bipolar I disorder (bipolar depression) AND the member must have documentation of clinically significant weight gain from baseline body weight at maximally tolerated efficacious dosage after initiation of therapy with generic olanzapine or member has documented intolerance to generic olanzapine that is unrelated to weight gain AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one of the following generic atypical antipsychotics: risperidone, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

LYNPARZA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g. Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)]. Adjuvant setting for High-Risk Early Breast Cancer: member is taking Lynparza (olaparib) total treatment for more than one year.
Required Medical Information	Breast Cancer: Member has a diagnosis of recurrent or metastatic breast cancer AND Member has deleterious germline or suspected germline BRCA-mutated disease as detected by an FDA-approved test AND Member has HER-2 negative disease, hormone receptor positive or negative, treated with prior chemotherapy and/or endocrine therapy AND Lynparza will be used as subsequent therapy as a single agent. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer First Line Maintenance Therapy: The member has a diagnosis of advanced epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND member's disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation or genomic instability. Member is in complete response or partial response to first line treatment with platinum based chemotherapy. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Second Line Maintenance Therapy: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Lynparza (olaparib) tablets as monotherapy. *Discontinue Avastin before initiating maintenance therapy with Lynparza. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Fourth Line Treatment: The member has a diagnosis of advanced ovarian cancer AND The member has deleterious or suspected deleterious germline BRCA mutation (as detected by an FDA-approved test) AND The member has been treated with three or more prior lines of chemotherapy AND The member will be using Lynparza (olaparib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration

Other Criteria	Pancreatic Adenocarcinoma - First line maintenance therapy: Member has a diagnosis of metastatic pancreatic adenocarcinoma AND member has deleterious germline or suspected germline BRCA-mutated disease AND member's disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen. Metastatic Castration-Resistant Prostate Cancer (mCRPC): Member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND Member has documented deleterious or suspected deleterious germline, or somatic homologous recombination repair (HRR) gene-mutated disease AND Member has experienced progressive disease following prior treatment with Xtandi (enzalutamide) or abiraterone AND Member will use Lynparza (olaparib) in combination with androgen deprivationtherapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog). Breast Cancer (Adjuvant): Member has a diagnosis of high-risk early breast cancer AND Member has deleterious germline or suspected germline BRCA-mutated disease as detected by an FDA-approved test AND Member has HER-2 negative disease, hormone receptor positive or negative, treated with prior chemotherapy AND Lynparza will be used as subsequent therapy as a single agent. High Risk early breast cancer defined as patients who: 1. Received prior neoadjuvant chemotherapy: patients with either triple negative breast cancer (TNBC) or hormone receptor positive breast cancer must have had residual invasive cancer in the breast and/or the resected lymph nodes (nonpathologic complete response) at the time of surgery. Additionally, patients with hormone receptor positive breast cancer must have had a score of greater than or equal to 3 based on pretreatment clinical and post-treatment pathologic stage (CPS), estrogen receptor (ER) status, and histologic grade. 2. TNBC with greater than or equal to pT2 or greater than or equal to pN1 prior to adjuvant chemotherapy 3. HR+/HER2-negative with greater than or equal to 4 positive lymph nodes prior to adjuvant chemotherapy.

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review

MEKINIST

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab), Keytruda (pembrolizumab), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib).] Adjuvant melanoma only: member is taking Mekinist (trametinib) total treatment for more than one year.
Required Medical Information	Melanoma-Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist as a single-agent (member has not received prior BRAF-inhibitor therapy) OR in combination with Tafinlar (dabrafenib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer(NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Mekinist (trametinib) in combination with Tafinlar (dabrafenib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist (trametinib) in combination with Tafinlar (dabrafenib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Metastatic Solid Tumors: the member has a diagnosis of unresectable or metastatic solid tumors with documented BRAF V600E mutation AND the member has disease that has progressed on prior therapy and has no satisfactory alternative treatments AND Mekinist is given in combination with Tafinlar.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

MEKTOVI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Tafinlar (dabrafenib), or Mekinist (trametinib) OR Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Colorectal Cancer - [Braftovi (encorafenib) requests only]: The member has documented BRAFV600E metastatic metastatic colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month durations or as determined through clinical review
Other Criteria	NA

memantine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Diagnosis of Autism or Atypical Autism (PDD)
Required Medical Information	NA
Age Restriction	An automatic approval if member is greater than 26 years of age.Prior Auth required for age 26 or younger.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration.
Other Criteria	NA

modafinil

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated with Narcolepsy,obstructive sleep apnea,or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). Steinert myotonic dystrophy syndrome.Member must have hypersomnia due to Steinert myotonic dystrophy syndrome.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

molindone

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older. Drug or alcohol induced severe central nervous system depression.
Required Medical Information	Schizophrenia: The member must utilize molindone hydrochloride for the management of clinically diagnosed schizophrenia. The member must have documentation of prior therapy, intolerance, or contraindication to two (2) of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	NA

MOZOBIL

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Treatment or prophylaxis of neutropenia or febrile neutropenia. Concomitant use with sargramostim or within seven days of pegfilgrastim dose.Same day administration with myelosuppressive chemotherapy or radiation.Use beyond four consecutive days or use after completion of stem cell harvest/apheresis.Mozobil is not intended for stem cell mobilization and harvest in patients with leukemia.
Required Medical Information	Autologous transplantation in patients with non-Hodgkin's Lymphoma (NHL) or Multiple Myeloma (MM): The member must have a diagnosis of non-Hodgkin's Lymphoma (NHL) or multiple myeloma (MM) AND Mozobil (plerixafor) must be used in combination with filgrastim, biosimilar filgrastim, or tbo-filgrastim AND Mozobil (plerixafor) must be a component of an autologous stem cell transplant mobilization protocol.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	30 days. Mozobil will be approved for a 30-day interval once per transplant.
Other Criteria	NA

MYALEPT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Partial lipodystrophy OR Liver disease including non-alcoholic steatohepatitis (NASH) OR HIV related lipodystophy OR Diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy OR Generalized obesity not associated with congenital leptin deficiency.
Required Medical Information	Congenital of Acquired Lipodystrophy: The member has a diagnosis of congenital OR acquired generalized lipodystrophy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

NATPARA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients with hypoparathyroidism caused by calcium-sensing receptor mutations.Patients with acute post-surgical hypoparathyroidism due to surgery within the past 4 months.
Required Medical Information	Hypocalcemia in patients with hypoparathyroidism: Member must have a diagnosis of hypocalcemia secondary to hypoparathyroidism
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

NERLYNX

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has disease progression on Nerlynx (neratinib). Member is taking Nerlynx (neratinib) total treatment for more than one year [applicable only to early stage breast cancer].
Required Medical Information	Early stage Breast Cancer: Initial Therapy. The member has early stage (i.e. Stage I, II, III) documented HER2 + positive disease AND The member has completed adjuvant therapy with a trastuzumab containing treatment AND Nerlynx (neratinib) is being used for the treatment in extended adjuvant setting AND The member is taking antidiarrheal prophylaxis (loperamide) concomitantly during the first two cycles. Continuation of therapy. The member is not experiencing any of the following situations: Grade 4 any adverse event [e.g., diarrhea, ALT (greater than 20 times ULN), bilirubin (greater than 10 times ULN)], Greater than or equal to grade 2 diarrhea with Nerlynx (neratinib dosing of 120mg per day AND If any of the above severe adverse reactions have been experienced, then provider has given a rationale for benefit of continued use that outweighs risk. Metastatic Breast Cancer. The member has metastatic or advanced breast cancer and all of the following apply: The member has documented HER2 positive disease and The member has received two or more prior anti-HER2 based regimens in the metastatic setting and Nerlynx (neratinib) is given in combination with capecitabine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Early stage: Initial - 3 months, Continuation therapy- 9 months. Metastatic or advanced: 6 months
Other Criteria	NA

NEULASTA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgastrim-sndz or filgastrim-aafi), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose). Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis. The member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than 2.0 mg/dL) OR Renal dysfunction (creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.

NEULASTA ONPRO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgastrim-sndz or filgastrim-aafi), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose). Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis. The member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than 2.0 mg/dL) OR Renal dysfunction (creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.

NEXAVAR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Nexavar (sorafenib).
Required Medical Information	Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV) AND the member has experienced intolerance, contraindication, or unable to achieve treatment goals with Cabometyx (cabozantinib) as second line therapy (e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma AND Tumors are not responsive to radio-iodine treatment. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND The member experienced disease progression with imatinib or Sutent (sunitinib) or Stivarga (regorafenib).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

NEXLETOL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must meet all of the following criteria: Diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR established atherosclerotic cardiovascular disease (ASCVD). One of the following: Used as adjunctive therapy after failure to achieve goal LDL-C reduction on maximally-tolerated statin (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR Statin Intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

NEXLIZET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Member meets all of the following criteria: Diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR established atherosclerotic cardiovascular disease (ASCVD). One of the following: Used as adjunctive therapy after failure to achieve goal LDL-C reduction on maximally-tolerated statin (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR Statin Intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

NINLARO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with proteasome inhibitors. Members with disease progression on Ninlaro (ixazomib).
Required Medical Information	Multiple Myeloma: second line. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least one prior therapy AND Ninlaro (ixazomib) will be used in combination with either dexamethasone OR lenalidomide and dexamethasone or cyclophosphamide and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication). Multiple Myeloma: third line or subsequent. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least two prior therapies AND Ninlaro (ixazomib) will be used in combination with pomalidomide and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) AND The members has demonstrated disease progression on or within 60 days of completion of the last therapy. Multiple Myeloma (maintenance): The member has a diagnosis of multiple myeloma AND Ninlaro (ixazomib) will be used as monotherapy AND Ninlaro (ixazomib) will be used as maintenance therapy. Multiple Myeloma: primary therapy. The member has a diagnosis of symptomatic multiple myeloma AND The request is for primary therapy AND One of the following sets of criteria applies: In combination with lenalidomide and dexamethasone AND member is not a transplant candidate OR in combination with cyclophosphamide and dexamethasone AND member is a transplant candidate. (Omission of corticosteroid from regimen is allowed if intolerance/contraindication).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

NIVESTYM

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrastim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose).
Required Medical Information	Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia AND biosimilar filgrastim must be used in adjunct with appropriate antibiotics in high risk members. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy: The member must have a diagnosis of non-myeloid malignancy (e.g. breast cancer, lung cancer) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to starting biosimilar filgrastim injections AND The member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication or dose-limiting neutropenic event from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR As secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 Months Duration

Other Criteria	Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation Chemotherapy AND the member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following Hematopoietic Stem Cell Transplant (HCST): The member must have had a Hematopoietic Stem Cell Transplant (HCST) (e.g. bone marrow transplant, peripheral-blood progenitor cell (PBPC) transplant) for a non-myeloid malignancy AND the member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, storing cells for a possible future autologous transplant, or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in AIDS patients. The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia. The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis.The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome. The member has been acutely exposed to myelosuppressive doses of radiation.

NOXAFIL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g. voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications.Treatment of Oropharyngeal or Esophageal Candidiasis.The member must have a diagnosis for orpharnygeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

NUBEQA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Nubeqa (darolutamide). Concomitant use with an androgen receptor inhibitor or androgen synthesis inhibitor (e.g. enzalutamide, abiraterone, nilutamide, flutamide, bicalutamide) due to lack of evidence supporting efficacy and safety.
Required Medical Information	Prostate Cancer (non-metastatic castration-resistant): The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND the member will use Nubeqa (darolutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

NUCALA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/ÂµL at therapy initiation OR greater than or equal to 300 cells/ÂµL in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Continuation of therapy: Member is currently stable on therapy. Member will continue on asthma controller inhalers: inhaled corticosteroids (ICS) with or without a long-acting beta2-agonist (LABA). Eosinophilic Granulomatosis with Polyangiitis (EGPA): The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND two or more systemic manifestations of EGPA. The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/ÂµL.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: Initial Review- The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Continuation of Therapy - The member must meet ALL of the following criteria: Improvement in symptoms (e.g., decrease in nasal congestion, decrease in polyp size, improvement in ability to smell) which has been sustained AND continuing intranasal corticosteroid spray therapy.

NUEDEXTA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pseudobulbar Affect: The member must have a diagnosis of Pseudobulbar Affect (PBA) secondary to brain injury or underlying neurologic disease (e.g., stroke, multiple sclerosis, ALS, Parkinson's disease, traumatic brain injury) AND The member is experiencing characteristic behavior episodes (e.g inappropriate laughing or crying) consistent with PBA at baseline AND the provider attests that the risk of QT prolongation with Nuedexta has been considered, and benefits of treatment outweigh risks. Reauthorization: Documented improvement in behavior with Nuedexta (e.g. reduction in episodes of inappropriate laughing or crying) AND the provider attests that the risk of QT prolongation with Nuedexta has been considered, and benefits of treatment outweigh risks.
Age Restriction	Member must be 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and Reauth: Plan Year Duration
Other Criteria	NA

NUPLAZID

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.
Required Medical Information	Parkinson's Disease Psychosis: The member is using Nuplazid for the treatment of hallucinations and delusions associated with Parkinson's disease (PD) psychosis AND the symptoms of psychosis have appeared after the diagnosis of PD AND psychosis is not related to other causes other than PD. Reauthorization: Documentation must be provided demonstrating an improvement in symptoms of psychosis.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 3 months. Reauthorization: 6 months.
Other Criteria	NA

octreotide acetate

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Acromegaly: The member must have a diagnosis of Acromegaly. Must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ODOMZO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Odomzo.
Required Medical Information	Basal Cell Carcinoma:The member has a diagnosis of locally advanced or metastatic basal cell carcinoma AND The member has experienced recurrence or disease progression following surgery or radiation OR has a contraindication to surgery or radiation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

OFEV

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a Chronic Fibrosing Interstitial Lung Disease[ILD] (e.g., Idiopathic Pulmonary Fibrosis [IPF], Hypersensitivity pneumonitis, Autoimmune ILD, Rheumatoid arthritis-associated ILD [RA-ILD], Systemic Sclerosis-associated ILD [SSc-ILD], Mixed Connective Tissue Disease-associated ILD, Idiopathic non-specific interstitial pneumonia, Unclassifiable Idiopathic Interstitial Pneumonia, Exposure-related ILDs, Sarcoidosis with Fibrosing ILD, in addition to other chronic fibrosing ILDs) confirmed by one of the following: Computer Tomography (CT) with evidence of fibrosis OR Lung Biopsy. Member has a progressive phenotype confirmed by one of the following: Diagnosis is for Idiopathic Pulmonary Fibrosis OR Has had a relative decline in FVC of at least 10% OR worsening respiratory symptoms OR increased extent of fibrotic change on CT scan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

OMNITROPE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Pediatric growth hormone discontinuation. Increase in height velocity is less than 2 cm total growth in one year of therapy: OR Final adult height has been achieved (member's calculated mid-parental height).The epiphyses have closed. Constitutional delay of growth and development. Skeletal dysplasias (e.g., achondroplasia, kyphomelic dysplasia). Osteogenesis imperfect. "Somatopause" in older adults.Infertility. Burn injuries. Obesity/morbid obesity. Hypophosphatemia (hypophosphatemic rickets). Muscular dystrophy. Cystic fibrosis. Spina bifida. Juvenile rheumatoid arthritis. Osteoporosis. Post-traumatic stress disorder. Depression. Hypertension. Corticosteroid-induced pituitary ablation. Precocious puberty. Chronic fatigue syndrome. Crohn's disease . Anti-aging . Growth retardation due to amphetamines. Chronic catabolic states, including respiratory failure, pharmacologic glucocorticoid administration, and inflammatory bowel disease. Down syndrome and other syndromes associated with short stature and increased susceptibility to neoplasms (Bloom syndrome, Fanconi syndrome).

OMNITROPE

Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT,glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m2 OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m2 and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m2 and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m2. Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex.Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex).Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome.Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.

ONUREG

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).
Required Medical Information	Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia AND The member is using Onureg (azacitidine) for post-remission therapy AND The member has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND The member is not able to complete or declines intensive curative therapy (e.g. allogeneic hematopoietic stem cell transplant) AND The member will use Onureg (azacitidine) as a single agent.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

OPSUMIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ORGOVYX

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with other LHRH agents. Pediatric members less than 18 years old.
Required Medical Information	Prostate Cancer: The member has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 Months Duration
Other Criteria	NA

ORKAMBI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis:The member has a diagnosis of Cystic Fibrosis.The member has documentation of a homozygous F508del mutation in the CFTR gene.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

OSPHENA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Undiagnosed abnormal genital bleeding. Known or suspected estrogen dependent neoplasia, OR Active DVT, pulmonary embolism (PE), or a history of these conditions, OR Active arterial thromboembolic disease (e.g. stroke and myocardial infarction or a history of these conditions).
Required Medical Information	The member must be a post-menopausal woman AND the member must have vulvar and/or vaginal atrophy AND the member must have moderate to severe dyspareunia. Treatment of moderate to severe vaginal dryness: The member must have moderate to severe vaginal dryness.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

OTEZLA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide), or a contraindication with all DMARDs. Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments OR the member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to topical corticosteroid therapy (e.g. triamcinolone oral paste).
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

OTEZLA STARTER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide), or a contraindication with all DMARDs. Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments OR the member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to topical corticosteroid therapy (e.g. triamcinolone oral paste).
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

oxandrolone

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Enhancement of athletic performance.
Required Medical Information	Cachexia associated with AIDS wasting syndrome: weight loss from cancer chemotherapy, severe burns, spinal cord injury, Corticosteroid-induced protein catabolism, Symptomatic treatment of bone pain accompanying osteoporosis, Alcoholic hepatitis, Turner Syndrome, Constitutional delay in growth and puberty, Duchenne muscular dystrophy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

PANRETIN

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of AIDS-related Kaposi's sarcoma AND systemic therapy is not required.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PEGASYS

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Pediatric members less than 3 years of age because safety and effectiveness have not been established, autoimmune disease, decompensated cirrhosis.
Required Medical Information	Chronic Hepatitis B – Adults: The member must have a diagnosis of chronic hepatitis B AND The member must have compensated liver disease AND The member must have evidence of viral replication AND The member must have evidence of liver inflammation AND The member must have had prior therapy, contraindication, or intolerance with tenofovir disoproxil fumarate AND entecavir. Chronic Hepatitis B – Pediatrics: The member must have a diagnosis of chronic hepatitis B AND The member must be non-cirrhotic AND The member must be HBeAg-positive AND The member must have evidence of viral replication AND The member must have elevation in serum alanine aminotransferase (ALT) AND the member must have had prior therapy, contraindication, or intolerance with tenofovir disoproxil fumarate AND entecavir. Chronic Hepatitis C – Adults: The member must have a diagnosis of chronic hepatitis C AND HCV ribonucleic acid (RNA) level must be documented prior to therapy AND The member has compensated liver disease AND Pegasys (peginterferon alpha-2a) will be taken in combination with at least 1 other medication indicated for the treatment of chronic Hepatitis C AND In members with genotypes 2 or 3, the member has had previous treatment, contraindication, or intolerance to Epclusa OR In members with genotyes 1,4,5 or 6, The member has had previous treatment, contraindication, or intolerance to Epclusa AND Harvoni. Chronic Hepatitis C – Pediatrics: The member must have a diagnosis of chronic hepatitis C AND HCV ribonucleic acid (RNA) level must be documented prior to therapy AND The member has compensated liver disease AND Pegasys (peginterferon alpha-2a) will be taken in combination with ribavirin AND In members with genotypes 2 or 3, the member has had previous treatment, contraindication, or intolerance to Epclusa OR In members with genotypes 1,4,5 or 6, the member has had previous treatment, contraindication, or intolerance to Epclusa AND Harvoni.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 to 120 week treatment course depending on the disease state and/or genotype.
Other Criteria	For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.

PEMAZYRE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experienced disease progression on Pemazyre (pemigatinib)
Required Medical Information	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic cholangiocarcinoma and the disease is fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test and the member has received prior treatment and Pemazyre (pemigatinib) is given as a single agent for subsequent therapy
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	NA

PERFOROMIST

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Asthma, in the absence of concurrent medication containing inhaled corticosteroid and comorbid COPD diagnosis.
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD).Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema, requiring maintenance treatment of bronchoconstriction.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

pimecrolimus

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Must have a diagnosis of atopic dermatitis or psoriasis have had previous treatment with one of the following topical generic products: triamcinolone 0.025%, 0.1%, 0.5% , mometasone, betamethasone dipropionate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

PIQRAY

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members have severe hypersensitivity to Piqray (alpelisib). Members has experienced disease progression on PIK3CA inhibitors (e.g., alpelisib).
Required Medical Information	Breast Cancer: The member has a diagnosis of advanced or metastatic hormone receptor positive, human epidermal growth factor receptor 2 (HER 2) negative breast cancer and PIK3CA mutated as detected by FDA approved test AND the member has experienced disease progression on or after endocrine based therapy within one year (e.g., anastrozole, palbociclib) AND Piqray (alpelisib) will be given in combination with fulvestrant as subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

pirfenidone

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF): The member meets ALL of the following criteria: Diagnosis of idiopathic pulmonary fibrosis by exclusion of clinically significant environmental exposure or explanation for pulmonary fibrosis or interstitial lung disease (e.g. drugs, asbestos, beryllium, radiation, and domestic birds, radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, or cancer). AND Documentation of Pulmonary Fibrosis by one of the following: computed tomography (CT) scan is indicative of usual interstitial pneumonia (UIP) OR a surgical lung biopsy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

POMALYST

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members receiving concomitant therapy with an immunomodulator. The member has experienced disease progression while on Pomalyst (pomalidomide).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member has received at least two previous therapies AND The member has demonstrated disease progression while on Revlimid (lenalidomide) OR Thalomid (thalidomide) AND The member demonstrated disease progression while on a protease inhibitor (e.g. bortezomib, carflizomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen [does not apply to requests for combination with Darzalex (daratumumab) plus dexamethasone or elotuzumab plus dexamethasone or Sarclisa (isatuximab) plus dexamethasone] AND The member will be using Pomalyst in one of the following regimens: in combination with dexamethasone and daratumumab, with dexamethasone and elotuzumab, with dexamethasone and ixazomib, with dexamethasone and cyclophosphamide, with dexamethasone, with dexamethasone and bortezomib, with dexamethasone and carfilzomib, dexamethasone and Sarclisa (isatuximab), dexamethasone and Xpovio (selinexor), or as a single agent (Omission of corticosteroid from regimen is allowed if intolerance/contraindication). Kaposi Sarcoma: The member has a diagnosis of AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy OR The member has a diagnosis of Kaposi sarcoma that is HIV-negative.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

posaconazole

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g. voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications.Treatment of Oropharyngeal or Esophageal Candidiasis.The member must have a diagnosis for orpharnygeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

PREVYMIS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Severe hepatic impairment (Child-Pugh C). End stage renal disease (Crcl less than 10mL/min). Members currently on dialysis.
Required Medical Information	Prophylaxis of CMV Infection and Disease in Adult CMV Seropositive Recipients [R+] of an Allogenic Hematopoietic Stem Cell Transplant (HSCT). Member must have received an allogeneic hematopoietic stem cell transplant. Member must be CMV-seropositive [R+]. Prevymis (letermovir) must be initiated within 28 days post-transplant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 Months Duration
Other Criteria	

PROCRIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer - first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks: Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR member has experienced symptom improvement and prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months for chemo induced anemia,HIV,HCV,MDS,RA,surgery. 6 months for CKD, CKD reauth: Plan Year

Other Criteria	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30 (within last 4 weeks). Cont. Therapy: has responded to therapy, defined as one or more of the following: An increase in hemoglobin of at least 1.5 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements, OR has experienced symptom improvement and prescriber determines to continue therapy. Cont. dosing is needed to maintain the lowest hemoglobin level (not to exceed 12 g/dL) sufficient to avoid RBC transfusion. Anemia associated with Management of Hepatitis C: anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above(within the last 4 weeks).Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA) Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30(within the last 4 weeks).Cont. Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the memberâ??s iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Cont. of therapy requires documented Transferrin saturation of at least 20% OR ferritin of at least 100 ng/mL within the last 4 months for all indications (applies to most recent result).

PROLASTIN-C

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	IgA deficient members or presence of antibodies against IgA.
Required Medical Information	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PROMACTA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	ITP members with previous documented failure of eltrombopag.
Required Medical Information	Chronic Idiopathic Thrombocytopenic Purpura. Initial Approval: The member has a diagnosis of relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) AND The member has a platelet count of less than 50 x 109/L. The member has had an insufficient response or is intolerant to corticosteroids OR The member has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Reauthorizations. The member has a platelet count of less than 400 x 109/L AND The member remains at risk for bleeding complications AND The member is responding to therapy as evidenced by increased platelet counts. Thrombocytopenia in Patients with Hepatitis C Infection: Initial Approval: The member has a diagnosis of chronic hepatitis C. The member has a platelet count of less than 75 x 109/L. The degree of thrombocytopenia is preventing the initiation of interferon therapy OR limits the ability to maintain optimal interferon based therapy. Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts AND The member continues to receive interferon based therapy. Aplastic Anemia: Initial Approval: The member has a diagnosis of aplastic anemia AND The member will receive Promacta (eltrombopag) in combination with immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin) for first-line treatment of severe aplastic anemia OR Promacta (eltrombopag) is being used for the treatment of refractory severe aplastic anemia in members with an insufficient response to immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin). Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

PYRUKYND

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hemolytic Anemia: the member has a diagnosis of pyruvate kinase deficiency with at least two mutant alleles in the PKLR gene, of which at least one is missense mutation. The member is not homozygous for the R479H mutation or had two non-missense, variants, without the presence of another missense variant in the PKLR gene. The member had a hemoglobin level less than or equal to 10g/dL. Continuation of therapy: member must meet the following criteria: efficacy of Pyrukynd (nitapivat) therapy as defined as: increase in hemoglobin by 1.5 g/dL or more from baseline hemoglobin OR decrease in transfusion requirements.
Age Restriction	
Prescriber Restriction	
Coverage Duration	Plan Year Duration
Other Criteria	Licensed Practitioner

QINLOCK

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on Qinlock (ripretinib).
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced GIST AND The member has received prior therapy with three or more kinase inhibitors, including imatinib AND Qinlock (ripretinib) is being used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

quinine sulfate

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
Required Medical Information	Plasmodium Falciparum Malaria: Diagnosis of uncomplicated chloroquine-resistant Plasmodium falciparum malaria. Brand Qualaquin request only: Members must have had previous treatment with generic Qualaquin(Quinine)or who have had contraindications or intolerance with generic Qualaquin(Quinine).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

rasagiline

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Member has a diagnosis of Parkinson's disease AND has had prior therapy with, contraindication, or intolerance to selegiline.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

REGRANEX

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Known neoplasm at the site of application.
Required Medical Information	Member must be using for the treatment of lower extremity diabetic ulcers AND the ulcer extends into the subcutaneous tissue or beyond AND the ulcer has an adequate blood supply AND Regranex will be used in combination with good ulcer care practices including debridement, pressure relief and prevention and treatment of infection.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

REPATHA PUSHTRONEX

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: maintenance of a reduction in LDL-C from baseline.
Age Restriction	Member must be 10 years of age or older for diagnosis of Primary Hyperlipidemia. Member must be 18 years of age or older for Clinical Atherosclerotic Cardiovascular Disease.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Primary Hyperlipidemia and ACSVD: Initial Auth 6 months. Reauth: Plan Year. HOFH: Plan Year.

Other Criteria	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: Maintenance of a reduction in LDL-C from baseline. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

REPATHA SURECLICK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: maintenance of a reduction in LDL-C from baseline.
Age Restriction	Member must be 10 years of age or older for diagnosis of Primary Hyperlipidemia. Member must be 18 years of age or older for Clinical Atherosclerotic Cardiovascular Disease.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Primary Hyperlipidemia and ACSVD: Initial Auth 6 months. Reauth: Plan Year. HOFH: Plan Year.

Other Criteria	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: Maintenance of a reduction in LDL-C from baseline. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

REPATHA SYRINGE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperlipidemia: Initial Authorization. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: maintenance of a reduction in LDL-C from baseline.
Age Restriction	Member must be 10 years of age or older for diagnosis of Primary Hyperlipidemia. Member must be 18 years of age or older for Clinical Atherosclerotic Cardiovascular Disease.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Primary Hyperlipidemia and ACSVD: Initial Auth 6 months. Reauth: Plan Year. HOFH: Plan Year.

REPATHA SYRINGE

Other Criteria	Clinical Atherosclerotic Cardiovascular Disease (ASCVD): Initial Authorization. The member must have documentation of an ASCVD (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) and SAMs symptoms included rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite both lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Reauthorization: Maintenance of a reduction in LDL-C from baseline. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR an untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

RETACRIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer - first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks: Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR member has experienced symptom improvement and prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion. Must meet ALL of the following criteria: Current-within the last 4 weeks Hgb level is low enough to necessitate transfusion (and Hgb is less than 10 g/dL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months for chemo induced anemia,HIV,HCV,RA,MDS,surgery. 6 months for CKD, CKD reauth: Plan Year.

Other Criteria	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: Diagnosis of symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30 (within last 4 weeks). Continue Therapy: The member has responded to therapy, defined as one or more of the following: An increase in hemoglobin of at least 1.5 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements, OR member has experienced symptom improvement and prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level (not to exceed 12 g/dL) sufficient to avoid RBC transfusion. Anemia associated with Management of Hepatitis C. Diagnosis of anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above (within the last 4 weeks).Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA) Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30(within the last 4 weeks).Continue Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Continuation of therapy requires documented Transferrin saturation of at least 20% OR ferritin of at least 100 ng/ mL within the last 4 months for all indications (applies to most recent result).

RETEVMO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on Retevmo
Required Medical Information	Non-small cell lung cancer. The member has a diagnosis of metastatic non-small lung cancer AND The disease is documented RET fusion positive AND Retevmo is being used as monotherapy. Medullary Thyroid cancer. The member has a diagnosis of metastatic or advanced medullary thyroid cancer AND The disease is documented RET mutant AND Retevmo is being used as a single agent for systemic therapy. Thyroid cancer. The member has a diagnosis of metastatic or advanced thyroid cancer AND The disease is documented RET fusion positive AND The disease is radioactive iodine refractory AND Retevmo is being used as a single agent for systemic therapy.
Age Restriction	For medullary thyroid cancer and thyroid cancer only: the member is 12 years and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

REVLIMID

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant Thalomid (thalidomide) or Pomalyst (pomalidomide).Members that have experienced disease progression while on Revlimid (lenalidomide).
Required Medical Information	Myelodysplastic Syndromes (MDS) with 5Q deletion. The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has a documented deletion 5q chromosomal abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has no documented 5q deletion abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Multiple Myeloma. Diagnosis of active Multiple Myeloma or Systemic Light Chain Amyloidosis. Primary induction OR for relapsed/refractory disease, Revlimid (lenalidomide) therapy should be utilized in conjunction with dexamethasone if no contraindication. As maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation. For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression/treatment failure. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL). For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

Other Criteria	Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease AND The member will be using for third line or subsequent systemic therapy. Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], primary cutaneous B-cell lymphoma, marginal zone lymphoma, or mantle cell lymphoma AND The member has relapsed or refractory disease OR The member has a diagnosis of follicular lymphoma AND The member will use as first line therapy or for relapsed or refractory disease.

REXULTI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Major depressive disorder: The member must have clinically diagnosed major depressive disorder AND The member must have documentation of prior therapy, intolerance, or contraindication to a generic oral atypical antipsychotic therapy AND at least one antidepressant therapy (ADT) AND Rexulti must be used as adjunctive or add-on treatment to ADT and not as monotherapy. Schizophrenia:The member must have clinically diagnosed schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to two generic oral atypical antipsychotic therapies.
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

REZUROCK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Rezurock (belumosudil).
Required Medical Information	Chronic Graft Versus Host Disease (cGVHD): The member has a diagnosis of chronic graft vs host disease (cGVHD) AND the member has been unable to achieve treatment goals with at least two prior lines of system therapy AND the member has a medical reason as to why Jakafi (ruxolitinib) cannot be started or continued. Reauthorization Criteria: Physician attestation that the member has continued to receive a clinical benefit (e.g. resolution of skin rash, reduction of GI symptoms, symptom improvement).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member has a diagnosis of moderate to severely active rheumatoid arthritis AND the member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide), or contraindication to all DMARDs. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, Enbrel). Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis AND the member has had prior therapy, contraindication or intolerance with at least one other systemic therapy (e.g. azathioprine, mycophenolate mofetil). Ulcerative Colitis: the member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with one or more TNF blockers (e.g. Humira). Ankylosing Spondylitis: the member has a diagnosis of ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with one or more TNF blockers (e.g. Humira, Enbrel).
Age Restriction	RA, Psoriatic Arthritis, UC, and ankylosing spondylitis: The member is 18 years of age or older. Atopic Dermatitis: the member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ROZLYTREK

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the member has disease which is ROS1-positive. Solid Tumors: the member has a diagnosis of solid tumors which are metastatic AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation AND The member is not a candidate for surgical resection AND The member's disease has progressed following treatment or does not have satisfactory alternative therapy options. Reauthorization: The member has not developed a known resistance to Rozlytrek (entrectinib) AND Physician attestation that the member has continued to receive a clinical benefit (e.g., complete response, partial response, stable disease) and has not experienced disease progression.
Age Restriction	Solid tumors: member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

RUBRACA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
Required Medical Information	Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Maintenance Therapy: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Rubraca (rucaparib) as monotherapy. *Discontinue Avastin before initiating maintenance therapy with Rubraca. BRCA-Mutated Advanced Ovarian Cancer:The member has a diagnosis of advanced ovarian cancer AND The member has deleterious BRCA mutation (germline and/or somatic) AND The member has been treated with two or more prior lines of chemotherapy AND The member will utilize Rubraca (rucaparib) as a monotherapy. Metastatic Castration-Resistant Prostate Cancer: The member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND The member has documented deleterious BRCA mutation (germline and/or somatic) AND The member has had prior treatment with androgen receptor-directed therapy (e.g. abiraterone, Xtandi, Erleada, or Nubeqa) and a taxane-based chemotherapy (e.g. docetaxel) AND The member will use Rubraca (rucaparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

rufinamide

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Patients with familial short QT syndrome.
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND the member has prior therapy with, contraindication or intolerance to at least one other drug indicated for LGS (e.g., topiramate, lamotrogine).
Age Restriction	Member is one year of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	History of seizures.
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS): The member has a confirmed diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) by a specialist (e.g. neurologist) AND The diagnosis is supported by results from a clinical evaluation (e.g. electromyography or the presence of autoantibodies directed against VGCC [voltage gated calcium channels]).
Age Restriction	The member is 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

RYDAPT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on or following Rydapt (midostaurin), Members with a diagnosis of therapy-related acute myeloid leukemia (defined as acute myeloid leukemia due to prior radiation therapy or prior chemotherapy used as therapy for a prior disorder or malignancy), Members with a diagnosis of acute promyelocytic leukemia (APL), Members that are using Rydapt (midostaurin) for post-consolidation therapy, Members that are using Rydapt (midostaurin) as a single agent induction therapy for acute myeloid leukemia
Required Medical Information	Acute Myeloid Leukemia-Newly diagnosed: The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Systemic Mastocytosis: The member has a diagnosis of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematologic neoplasm (SM-AHN), or mast cell leukemia (MCL). Acute Myeloid Leukemia - Relapsed/Refractory: The member has relapsed or refractory acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use for prophylaxis of HAE attack. Evidence of autoantibodies against the C1INH protein. Evidence of underlying lymphoproliferative, malignant, or autoimmune disorder that causes angioedema attacks. Use in combination with other agents approved for acute treatment of HAE attack (e.g. Berinert, Kalbitor, Ruconest).
Required Medical Information	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Low evidence of C4 level (i.e. C4 level below lower limit of normal laboratory reference range) AND Low C1 inhibitor (i.e. C1INH level below lower limit of normal laboratory reference range) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (i.e. functional C1INH less than 50% or below lower limit of normal laboratory reference range) OR Known HAE-causing C1INH mutation. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level. The member is using icatibant for treatment of acute attacks of HAE.
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Acromegaly: The member must have a diagnosis of Acromegaly. Must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

sapropterin

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Initial: The member has a diagnosis of PKU. Reauth - The member has tetrahydobiopterin -(BH4) responsive PKU defined by: The member has achieved a greater than or equal to a 20% reduction in blood phenylalanine concentration from pre-treatment baseline OR the member has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescriber.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	First approval: three months. if response is positive extended for plan year duration.
Other Criteria	NA

SCEMBLIX

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Scemblix (asciminib).
Required Medical Information	Chronic Myeloid Leukemia (chronic phase): The member has a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase AND One of the following applies: The member has had intolerance, resistance, or contraindication to at least two available tyrosine kinase inhibitors OR The member has T315I mutation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

SECUADO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.
Required Medical Information	Schizophrenia: The member has diagnosis of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

SIGNIFOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Cushing's disease: Diagnosis of Cushing's disease AND Pituitary surgery is not an option or has not been curative AND No severe hepatic impairment (Child-Pugh C).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months for initial approval.
Other Criteria	Reauthorization criteria for additional 180 days are as follows: No severe hepatic impairment (Child-Pugh C AND Urinary Free Cortisol (UFC) level has decreased from baseline at start of Signifor (pasireotide) treatment.

sildenafil (pulm.hypertension)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH).The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had prior therapy, contraindication, or intolerance to a phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multidrug-resistant tuberculosis (MDR-TB). The member must have a diagnosis of pulmonary multidrug-resistant tuberculosis (MDR-TB) confirmed by drug susceptibility testing (DST). Bedaquiline will be used as part of a multidrug regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	24 weeks duration
Other Criteria	

SKYRIZI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide), or contraindication with all DMARDS. Moderately to severely active Crohn's disease: member has a diagnosis of moderately to severely active Crohn's disease AND the member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g., prednisone, methylprednisolone) or an immunomodulator (e.g., azathioprine, 6-mercaptopurine, methotrexate).
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

SOMATULINE DEPOT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Diagnosis of acromegaly. The patient has a diagnosis of acromegaly. The patient has had an inadequate response to or cannot be treated with surgical resection OR The patient has had an inadequate response to or cannot be treated with radiation therapy. Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Carcinoid Syndrome: The member has a diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

SOMAVERT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acromegaly. The member must have a diagnosis of acromegaly. The member had inadequate response to surgery or radiation therapy, AND one dopamine agonists (i.e. bromocriptine)or one somatostatin analogues (i.e. octreotide, lanreotide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

sorafenib

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Nexavar (sorafenib).
Required Medical Information	Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV) AND the member has experienced intolerance, contraindication, or unable to achieve treatment goals with Cabometyx (cabozantinib) as second line therapy (e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma AND Tumors are not responsive to radio-iodine treatment. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND The member experienced disease progression with imatinib or Sutent (sunitinib) or Stivarga (regorafenib).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

SOVALDI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Monotherapy with Sovaldi.
Required Medical Information	Chronic Hepatitis C - Adults: Must have a diagnosis of chronic hepatitis C with liver disease. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. HCV genotype has been documented. GT1 and 4: Member must have failed to achieve SVR after completing a full course of or has a contraindication to Harvoni AND Epclusa. GT2 and 3: Member must have failed to achieve SVR after completing a full course of or has a contraindication to Eplusa. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance. Chronic Hepatitis C - Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 2 or 3 infection. HCV RNA level must be documented prior to therapy. Sovaldi must be used in combination with ribavirin. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For members 6 years of age OR weighing at least 17 kg: the member has relapsed after completing a full course of or has a contraindication to Epclusa.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	12 to 48 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	For all indications, dosing recommendations will be applied consistent with current AASLD-IDSA and compendia guidance.

SPRYCEL

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors, Members that have experienced disease progression while on dasatinib. For ALL and CML: The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	Chronic Myelogenous Leukemia (CML): The member has a diagnosis of Ph+ chronic myeloid leukemia (CML) and one of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Bosulif (bosutinib) OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib and Bosulif (bosutinib) OR The member has a diagnosis of chronic phase CML that has received previous treatment AND Low, intermediate-, or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Bosulif (bosutinib). Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive)and Sprycel is being used for induction or consolidation treatment in combination with chemotherapy or corticosteroids OR treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy. Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib) or Sutent (sunitinib)or Stivarga. [Pediatric] Chronic Myelogenous Leukemia (CML). The member has a diagnosis of chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) AND the member is in chronic phase. [Pediatric] Acute lymphoblastic leukemia (ALL). The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member has Philadelphia chromosome positive (Ph+) disease AND the member has newly-diagnosed disease AND The member will be using Sprycel in combination with chemotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had proir therapy or intolerance to one or more oral systemic tretaments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis AND the member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychoroquine, leflunomide), or contraindication with all DMARDS. Moderately to severely active Crohn's disease (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease AND the member has had prior therapy, contraindication, or intolerance to a corticosteroid (e.g. prednisone, methylprednisolone) or an immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate). The member must have a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) (e.g. mesalamine, balsalazide) OR Corticosteroids (e.g. prednisone, methylpredisolone) PR immunomodulators (e.g. azathioprine, 6-mercaptopurine).
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For all other indications: Must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

STIVARGA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Stivarga (regorafenib).Members on concomitant tyrosine kinase inhibitors.
Required Medical Information	Metastatic Colorectal Cancer.The member has a diagnosis of metastatic colorectal cancer AND The member is using Stivarga (regorafenib) as monotherapy AND The member has documented intolerance, contraindication or has failed previous treatment with ALL of the following therapies: fluoropyrimidine (regimens include 5-FU/capecitabine),oxaliplatin-based chemotherapy,irinotecan-based chemotherapy, and anti-VEGF therapy (e.g., bevacizumab, ziv-aflibercept) AND If the member is RAS wild-type and has documented intolerance, contraindication or has failed previous treatment with anti-EGFR therapy (e.g., cetuximab, panitumumab).Gastrointestinal Stromal Tumor.The member has a diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor AND The member has experienced disease progression, intolerance, or contraindication with imatinib mesylate and sunitinib malate. Hepatobiliary Cancers: The member has a diagnosis of hepatocellular carcinoma AND Stivarga (regorafenib) is being given as monotherapy AND The member has experienced progression after first line theapy (e.g., sorafenib). Soft Tissue sarcoma. Diagnosis of advanced or metastatic soft tisuse sarcoma (i.e., angiosarcoma, solitary fibrous tumor, non-adipocytic sarcoma, pleomorphic rhabdomyosarcoma) AND Stivarga (regorafenib) is being given as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Month Duration
Other Criteria	

STRENSIQ

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Hypophosphatasia (HPP):The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile onset hypophosphatasia. 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 Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Auth: 6 months. Reauth: Plan Year Duration.
Other Criteria	Continuation of Therapy: The member is experiencing clinical benefit from Strensiq therapy (e.g. improvement in skeletal manifestations, gait/mobility, growth, etc).

sunitinib

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Sutent. Member not to exceed a total treatment of 54 weeks (applicable to adjuvant therapy for renal cell carcinoma).
Required Medical Information	Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST)AND the member has disease progression on or intolerance to imatinib mesylate. Advanced renal cell carcinoma (RCC).Diagnosis of advanced renal cell carcinoma (stage IV). Renal Cell Carcinoma (RCC) Adjuvant Therapy. The member has high risk (i.e. tumor stage T3 or higher, regional lymph node metastases, or both) of recurrent RCC following nephrectomy AND Sutent (sunitinib) will be used as a single agent as adjuvant treatment. Pancreatic neuroendocrine tumors (PNET). Diagnosis of Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) AND The member has unresectable locally advanced or metastatic disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular carcinoma, Hurthle cell carcinoma, papillary (types of thyroid carcinoma) and are not responsive to radio-iodine treatment and clinical trials are not available or appropriate. OR The member has a diagnosis of advanced medullary carcinoma-disseminated symptomatic disease (type of thyroid carcinoma) and has disease progression or has an intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Soft Tissue sarcoma. Diagnosis of soft tisuse sarcoma (Angiosarcoma or Solitary Fibrous Tumor or Alveolar soft part sarcoma) AND Sutent (sunitinib) is being utilized as a single agent/monotherapy (without concomitant chemotherapy or biologics).Thymomas/thymic carcinoma: The member will be using as monotherapy in the second line.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

SYMDEKO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystic Fibrosis: The member has a diagnosis of Cystic Fibrosis AND member has documentation of a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on clinical literature and/or in vitro assay data.
Age Restriction	The member is aged 6 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

SYMPAZAN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of Lennox-Gastaut Syndrome AND the member will be taking at least one concomitant anti-epileptic medication therapy AND the member has had prior therapy AND has a documented contraindication (e.g. dysphagia) to BOTH a generic clobazam tablet AND oral suspension formulation.
Age Restriction	The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA

SYNRIBO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Synribo (omacetaxine mepesuccinate).
Required Medical Information	Chronic Myelogenous Leukemia. The member has a diagnosis chronic or accelerated phase chronic myeloid leukemia AND one of the following applies: The member has had prior therapy, intolerance, or resistance to at least two of the following tyrosine kinase inhibitors: imatinib, Sprycel, Tasigna, or Bosulif OR The member has a documented T315I mutation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	

TABRECTA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on Tabrecta (capmatinib).
Required Medical Information	Non-Small Lung Cell Cancer (NSCLC): The member has a diagnosis of metastatic NSCLC AND the disease is documented MET exon 14 skipping positive AND Tabrecta (capmatinib) is being used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

tadalafil (pulm. hypertension)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

TAFINLAR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab), Keytruda (pembrolizumab) Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Tafinlar (dabrafenib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)]. Adjuvant melanoma only: member is taking Tafinlar (dabrafenib) total treatment for more than one year.
Required Medical Information	Melanoma-Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenib) as monotherapy OR in combination with Mekinist (trametinib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer (NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenic) in combination with Mekinist (trametinib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Metastatic Solid Tumors: the member has a diagnosis of unresectable or metastatic solid tumors with documented BRAF V600E mutation AND the member has disease that has progressed on prior therapy and has no satisfactory alternative treatments AND Tafinlar is given in combination with Mekinist.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

TAGRISSO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors. Members who have disease progression on Tagrisso (osimertinib). Total treatment exceeds three years (applicable to adjuvant therapy in NSCLC).
Required Medical Information	Non small cell lung cancer NSCLC:The member has a diagnosis of metastatic non small cell lung cancer (NSCLC) and the following criteria applies: The member has documented sensitizing EGFR mutations (exon 19 deletions or exon 21 L858R) AND Tagrisso (osimertinib) is being used as single agent for first line therapy OR The member has a documented epidermal growth factor receptor (EGFR) T790M mutation AND Tagrisso (osimertinib) is used as monotherapy after progression of EGFR inhibitors (e.g., erlotinib, gefitinib). Non-small cell lung cancer (NSCLC) [Adjuvant therapy]: The member has a diagnosis of NSCLC (i.e., Stage Ib- IIIA) AND The member has documented sensitizing EGFR mutations (exon 19 deletions or exon 21 L858R) AND The tumor has been resected AND Member will taking (osimertinib) as a single agent for adjuvant therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

TALZENNA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members have experienced disease progression while on or following PARP inhibitor therapy (eg, olaparib).
Required Medical Information	Breast Cancer. Member has a diagnosis of locally advanced or metastatic, HER-2 negative breast cancer AND Member has documented deleterious germline or suspected germline BRCAmutated disease AND if member has hormone receptor positive disease then is endocrine refractory AND Talzenna (talazoparib) will be used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

TARGRETIN

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that are pregnant. Members on concomitant retinoid therapy.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

TASIGNA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Tasigna (nilotinib). For ALL and CML: The member has one of the following mutations: T315I, Y253H, E255K/V, F359V/C/I or G250E.
Required Medical Information	Chronic Myelogenous Leukemia (CML). The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated, and one of the following applies: Intermediate- or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Bosulif (bosutinib) OR Low-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib and Bosulif (bosutinib) OR The members has a diagnosis of chronic phase CML that has received previous treatment AND: Low, Intermediate-, or high-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with Bosulif (bosutinib). Advanced Gastrointestinal Stromal Tumor (GIST). Diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib), Sutent (sunitinib),or Stivarga.Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia. Pediatric CML: Diagnosis of chronic phase Ph+ chronic myeloid leukemia (CML) OR diagnosis of accelerated phase Ph+ chronic myeloid leukemia (CML) AND resistance, intolerance, or contraindication to prior TKI therapy.
Age Restriction	Pediatric CML- member is greater than or equal to 1 year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

tazarotene

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The treatment of acne vulgaris: The member must have a documented diagnosis of acne vulgaris AND The member must have had previous treatment, or intolerance to generic topical tretinoin (non-micro)*. The treatment of stable plaque psoriasis: The member must have a documented diagnosis of stable plaque psoriasis AND The member must have had previous treatment , intolerance, or contraindication with topical betamethasone dipropionate or triamcinolone 0.5%. *Generic topical tretinoin (non-micro) has additional prior authorization requirements.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

TAZVERIK

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member experiences disease progression on Tazverik
Required Medical Information	Epithelioid Sarcoma: The member has a diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection AND Tazverik will be given as monotherapy. Follicular lymphoma: The member has a diagnosis of relapsed/refractory follicular lymphoma AND one of the following applies: The member has a documented EZH2 mutation by an FDA approved test and the member has received at least two prior therapies and the member will be using Tazverik (tazemetostat) as monotherapy OR The member has no satisfactory alternative treatment options and The member will be using Tazverik (tazemetostat) as monotherapy.
Age Restriction	The member is 16 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

TECFIDERA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

TEMODAR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Temozolomide is contraindicated in member with a history of hypersensitivity to dacarbazine.
Required Medical Information	Glioblastoma Multiforme/ Anaplastic Astrocytoma: The member is an adult with glioblastoma multiforme (GBM)or anaplastic astrocytoma and Temodar (temozolomide) is being used as the following: Newly diagnosed GBM or anaplastic astrocytoma as a single agent or in combination with radiotherapy OR Maintenance therapy for GBM or anaplastic astrocytoma or treatment of recurrent disease as a single agent or in combination with bevacizumab product for GBM or anaplastic astrocytoma. Low Grade Gliomas: The member is an adult with low grade infiltrative supratentorial astrocytoma or oligodendroglioma AND The member has disease progression on a regimen containing carmustine, lomustine, or procarbazine AND The member must use Temodar (temozolomide) as a single agent for recurrent or progressive disease OR The member must use Temodar (temozolomide) as a single agent as adjuvant thearpy. Ewing's Sarcoma: The member has Ewing's sarcoma and Temodar (temozolomide) is being used in combination with irinotecan for one of the following: Relapse therapy. Progressive disease following primary treatment. Melanoma: The member has diagnosis of unresectable or recurrent melanoma and Temodar (temozolomide) is being used as a single agent for subsequent therapy. Neuroendocrine Tumors of the Pancreas: The member has diagnosis of unresectable locoregional and/or distant metastatic neuroendocrine tumors of the pancreas (islet cell tumors) and Temodar is being as single agent or in combo with Xeloda for the management of symptomatic disease, clinically significant tumor burden or clinically significant progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

Other Criteria	Neuroendocrine Tumors of the Lung or Thymus: The member has locoregional or metastatic neuroendocrine carcinoma and Temodar (temozolomide)is being used as a single agent. Mycosis fungoides (MF)/Sezary syndrome(SS): The member has a diagnosis of MF/SS. Primary Central Nervous System (CNS) Lymphoma: The member has a diagnosis or primary CNS lymphoma and will be using Temodar (temozolomide) in combination with high-dose methotrexate and rituximab product OR The member has progressive or recurrent primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent or in combination with rituximab product. Soft tissue sarcoma: The member has diagnosis of soft tissue sarcoma. Anaplastic Gliomas. The member has diagnosis of Anaplastic Gliomas and Temodar (temozolomide) will be used as monotherapy and one of the following applies: adjuvant treatment or recurrent disease OR Temodar (temozolomide) will be given in combination with bevacizumab product for treatment of recurrent disease.

TEPMETKO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	The member experiences disease progression on MET inhibitor (e.g., Tabrecta, Tepmetko).
Required Medical Information	Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC AND The disease is documented MET exon 14 skipping positive AND The member has a medical reason as to why Tabrecta (capmatinib) cannot be started or continued AND Tepmetko (tepotinib) is being used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	NA

testosterone

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

tetrabenazine

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of chorea associated with Huntington's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

THALOMID

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members on concomitant Revlimid (lenalidomide) or Pomalyst (pomalidomide). Members that have experienced disease progression while on thalidomide.
Required Medical Information	Thalomid (thalidomide) will require prior authorization and may be considered medically necessary when the following criteria are met for the following indication(s):Erythema Nodosum Leprosum (ENL).The member is currently having acute cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) OR Thalomid (thalidomide) is prescribed for maintenance therapy for prevention and suppression of the cutaneous manifestations of (ENL) recurrence.Multiple Myeloma.The member has a diagnosis of Multiple Myeloma. Waldenstöm's Macroglobulinemia.The member has a diagnosis of Waldenstöm's macroglobulinemia or lymphoplasmacytic lymphoma AND Thalomid (thalidomide) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Thalomid (thalidomide) is being used as monotherapy or in combination with a rituximab product.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

TIBSOVO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Tibsovo (ivosedinib).
Required Medical Information	Acute Myeloid Leukemia- Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND one of the following applies: The member will be using Tibsovo (ivosedinib) as monotherapy OR the member will be using Tibsovo as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia Newly diagnosed: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has newly diagnosed disease AND one of the following applies: the member is 60 years of age or older and is not a candidate for intensive induction therapy due to comorbidities OR the member is 60 years of age or older and the member declines intensive induction therapy OR the member is 75 years of age or older. The member has a documented IDH1 mutation as detected by an FDA-approved test AND the member will be using Tibsovo as monotherapy or in combination with azactidine. Cholangiocarcinoma: The member has locally advanced or metastatic cholangiocarcinoma AND the disease has documented isocitrate dehydrogenate-1 (IDH1) mutation AND Tibsovo (ivosedinib) will be a subsequent therapy and used as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

tobramycin

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 80% predicted. Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa.
Age Restriction	Must be 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

tobramycin with nebulizer

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 80% predicted. Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa.
Age Restriction	Must be 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

tolvaptan

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Use in patients with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS. Need to raise serum sodium acutely. Patients who are unable to respond appropriately to thirst. Hypovolemic hyponatremia. Anuria.
Required Medical Information	Tolvaptan (generic Samsca) will be used for the treatment of clinically significant hypervolemic or euvolemic hyponatremia AND tolvaptan (generic Samsca) therapy has been initiated in a hospital.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

tretinoin

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved or compendia supported, non-cosmetic indications.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	NA

TRIKAFTA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member has a diagnosis of Cystic Fibrosis AND Member does not have severe liver impairment (Child-Pugh Class C) AND Submission of Lab testing to confirm at least one F508del mutation or a mutation in the CFTR gene that is responsive based on in vitro data.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

TRUSELTIQ

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on FGFR2 inhibitors (e.g., infigratinib, pemigatinib).
Required Medical Information	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic cholangiocarcinoma AND The cholangiocarcinoma is fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test AND The member has received prior treatment AND Truseltiq (infigratinib) is given as a single agent for subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

TUKYSA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experiences disease progression on Tukysa (tucatinib)
Required Medical Information	Breast Cancer. The member has metastatic or advanced unresectable HER 2 positive breast cancer (inclusive of brain metastases) and all of the following apply: Member has received one or more prior anti-HER2 based regimen in the metastatic setting AND Tukysa is given in combination with trastuzumab product and capecitabine as subsequent therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

TURALIO

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Symptomatic Tenosynovial Giant Cell Tumor: The member has symptomatic tenosynovial giant cell tumor (TGCT) and the disease is associated with severe morbidity or functional limitations and the disease is not amenable to improvement with surgery and Turalio (pexidartinib) will be used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

TYKERB

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progressionwhile on Tykerb (lapatinib).
Required Medical Information	Breast Cancer. The member has a diagnosis of HER2(human epidermal growth factor receptor2) positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline (e.g. doxorubicin) and a taxane (e.g.paclitaxel)OR The member has a diagnosis of HER2 positive metastatic breast cancer AND Used as first line treatment in combination with an aromatase inhibitor (Femara/letrozole, Arimidex/anastrozole or Aromasin/exemestane) for hormone receptor positive disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA

TYMLOS

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member is postmenopausal with a diagnosis of osteoporosis. The member is at high risk for osteoporotic fracture as evident by the following: The member has a history of osteoporotic fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication or intolerance with an oral OR intravenous bisphosphonate (e.g. alendronate).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

UDENYCA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgastrim-sndz or filgastrim-aafi), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose). Same day administration with myelosuppressive chemotherapy or therapeutic (Administration of pegfilgrastim occurs no less than 24 hours following myelosuppressive chemotherapy). Cannot be given more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis. The member must have a diagnosis of non-myeloid malignancy (e.g. solid tumors) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to pegfilgrastim injection AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen, and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy OR Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours) OR Bone marrow involvement by tumor OR Recent surgery and/or open wounds OR Liver dysfunction (bilirubin greater than 2.0 mg/dL) OR Renal dysfunction (creatinine clearance less than 50 mL/min) OR Age greater than 65 receiving full chemotherapy dose intensity Or Previous neutropenic fever complication from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.

VALCHLOR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Valchlor (mechlorethamine).
Required Medical Information	Cutaneous T-Cell Lymphoma: The member has a diagnosis of fungoides-type cutaneous T-cell lymphoma AND The member has had prior therapy with skin-directed therapy or using as primary treatment.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

vancomycin

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	C. difficile-associated diarrhea: The member must have a diagnosis of C. difficile-associated diarrhea. Enterocolitis caused by staphylococcus aureus (including methicillin-resistant strains): The member must have a diagnosis of enterocolitis caused by staphylococcus aureus (including methicillin-resistant strains).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

VENCLEXTA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) and one of the following applies: has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with rituximab OR the request is for first-line therapy AND the member is using Venclexta (venetoclax) in combination with Gazyva (obinutuzumab). Mantle Cell Lymphoma: The member has a diagnosis of MCL AND The member is using Venclexta (venetoclax) as monotherapy or in combination with a rituximab product AND The member meets one of the following: relapsed, refractory, or progressive disease OR Stable disease or partial response after induction therapy. Acute Myeloid Leukemia - Newly Diagnosed: The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND one of the following applies: member is 75 years or older OR member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min). The member will be using Venclexcta (ventoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine. Acute Myeloid Leukemia – relapsed/refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed/refractory disease AND One of the following applies: As a component of repeating the initial successful induction regimen if late relapse (greater than or equal to 12 months since induction regimen) AND Venclexta (venetoclax) has not been administered continuously AND Venclexta (venetoclax) was not stopped due to the development of clinical resistance OR The member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) and one of the following applies: has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with rituximab OR the request is for first-line therapy AND the member is using Venclexta (venetoclax) in combination with Gazyva (obinutuzumab). Mantle Cell Lymphoma: The member has a diagnosis of MCL AND The member is using Venclexta (venetoclax) as monotherapy or in combination with a rituximab product AND The member meets one of the following: relapsed, refractory, or progressive disease OR Stable disease or partial response after induction therapy. Acute Myeloid Leukemia - Newly Diagnosed: The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND one of the following applies: member is 75 years or older OR member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min). The member will be using Venclexcta (ventoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine. Acute Myeloid Leukemia – relapsed/refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed/refractory disease AND One of the following applies: As a component of repeating the initial successful induction regimen if late relapse (greater than or equal to 12 months since induction regimen) AND Venclexta (venetoclax) has not been administered continuously AND Venclexta (venetoclax) was not stopped due to the development of clinical resistance OR The member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

VENTAVIS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (WHO GROUP I):The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization with WHO/NYHA Function Class IV symptoms OR the member must have had prior therapy, intolerance to, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist [e.g., ambrisentan, bosentan, Opsumit (macitentan)) approved for use in PAH.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

VERSACLOZ

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had prior therapy or intolerance to generic clozapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

VERZENIO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is on concomitant palbociclib or ribociclib. Member has experienced disease progression on Faslodex (fulvestrant) [applies to combination therapy with Faslodex (fulvestrant)]. Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, ribociclib). Member exceeds two years of total Verzenio (abemaciclib) based treatment (applicable only to early breast cancer).
Required Medical Information	Metastatic Breast cancer- initial endocrine based therapy. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND Verzenio (abemaciclib) is given in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine based therapy. Metastatic breast cancer combination therapy with Faslodex (fulvestrant). The member has diagnosis of advanced or metastatic hormone receptor (HR) positive human epidermal growth factor receptor 2 (HER2) negative breast cancer AND The member has experienced disease progression on endocrine therapy (e.g., anastrazole) AND Verzenio (abemaciclib) is given in combination with Faslodex (fulvestrant). Metastatic breast cancer monotherapy: The member has diagnosis of advanced or metastatic HR positive, HER2 negative breast cancer AND the member has experienced disease progression on endocrine therapy (e.g., anastrazole) and chemotherapy in the metastatic setting AND Verzenio (abemaciclib) is being used as monotherapy. Early Breast cancer - combination therapy: The member has a diagnosis of HR positive, HER2 negative, node positive, early breast cancer at high risk of recurrence AND The breast cancer has documented Ki-67 score greater than or equal to 20% AND Verzenio (abemaciclib) is given in combination with tamoxifen or aromatase inhibitor.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

vigabatrin

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Complex Partial Seizure: Documented diagnosis of refractory complex partial seizure. Unsuccessful treatment with at least two concomitant antiepileptic drugs (AEDs) (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

vigadrone

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Complex Partial Seizure: Documented diagnosis of refractory complex partial seizure. Unsuccessful treatment with at least two concomitant antiepileptic drugs (AEDs) (e.g. carbamazepine, lamotrigine, levetiracetam, topiramate). Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

VIIBRYD

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member must be utilizing Viibryd (vilazodone) for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

vilazodone

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member must be utilizing Viibryd (vilazodone) for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

VITRAKVI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Solid Tumors. Member has been diagnosed with advanced or metastatic solid tumor AND Member has a documented neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known resistance mutation AND Member is not a candidate for surgical resection AND Member is not a candidate for or does not have alternative systemic therapy treatment options. Reauthorization: Member has not developed a known resistance mutation to Vitrakvi (larotrectinib) AND Physician attestation that the member has continued to receive a clinical benefit (e.g., complete response, partial response, stable disease) and has not experienced disease progression.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 90 days. Reauthorization: Six month duration
Other Criteria	NA

VIZIMPRO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant tyrosine kinase inhibitors.
Required Medical Information	Non-small cell lung cancer (NSCLC). The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following criteria applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Vizimpro (dacomitinib) as a single agent for first line therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

VONJO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Vonjo (pacritinib).
Required Medical Information	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-risk disease OR High-risk disease AND The member will be using Vonjo (pacritinib) as monotherapy AND The member has a platelet count below 50 x 109/L. Reauthorization criteria: Physician attestation that the member has continued to receive a clinical benefit (e.g. spleen volume reduction from baseline, symptom improvement) AND Physician attestation that the member has not experienced unacceptable toxicities.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Authorization: 6 months duration. Reauthorization: 6 months duration
Other Criteria	

voriconazole

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Antifungal Prophylaxis in members undergoing bone marrow transplants. Antifungal Prophylaxis in members who are intermediate or high risk of developing cancer-related fungal infections. Prophylaxis of Aspergillus species in post-heart transplantation patients should meet one of the following: CMV disease,Isolation of Aspergillus species in respiratory tract cultures,Post-transplant hemodialysis or Reoperation, Existence of an episode of invasive aspergillosis in heart transplant program two months before or after heart transplant.Prophylaxis of both Candida and Aspergillus species in high risk post-liver transplant patients should meet one of the following criteria: Local epidemiology, Renal failure needing hemodialysis or continuous venovenous dialysis pre- or post-transplantation, Reoperation involving thoracic or abdominal cavity (exploratory laparotomy, or intrathoracic surgery), Retransplantation OR Transplantation for fulminant hepatic failure. Prophylaxis of invasive aspergillosis in post-lung transplantation,Treatment of invasive aspergillosis, Treatment of chronic cavitary or necrotizing pulmonary aspergillosis and/or Serious fungal infections cause by Scedosporium apiospermum and Fusarium spp. including Fusarium solani, in patients intolerant of other therapy OR Empiric therapy of suspected invasive Candidiasis or Aspergillosis in high risk patients with febrile neutropenia despite receiving broad-spectrum antibiotic therapy. Diagnosis of one of the following fungal infections and failed to achieve clinical response or has contraindications to fluconazole or itraconazole for sensitive (non-krusei, non-glabrata) candida infections: Esophageal candidiasis, Oropharyngeal candidiasis,Candidemia in nonneutropenic patients and/or The following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and/or wounds.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Retreatment of Chronic Hepatitis C. The member must have a diagnosis of chronic hepatitis C (HCV). The member must have HCV genotype documented prior to therapy. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. The member has relapsed after completing a full course of or has a contraindication to: Genotypes 1, 4, 5, and 6: Harvoni AND Epclusa. Genotypes 2 and 3: The member has relapsed after completing a full course of or has a contraindication to Epclusa.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	

VOTRIENT

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on previous pazopanib therapy.
Required Medical Information	Advanced Renal Cell Carcinoma RCC).The member has a diagnosis of advanced renal cell carcinoma (stage IV). First-line therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology OR as subsequent therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology in members who have progressed on prior first-line therapy.Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma AND The member has progressed after prior chemotherapy. Thyroid Carcinoma: The member has a diagnosis of advanced or metastatic radio-iodine refractory follicular carcinoma, Hürthle cell carcinoma, papillary and disease is progressive OR The member has a diagnosis of advanced medullary carcinoma and has disease progression on or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Ovarian Cancer. The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer. Uterine Neoplasms. The member has a diagnosis of stage II, III, IV, or advanced metastatic uterine neoplasm sarcoma and disease is not suitable for primary surgery AND Votrient (pazopanib) will be used as a single agent.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA

VRAYLAR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Schizophrenia/ Bipolar I Disorder, manic or mixed episode: The member must be utilizing Vraylar for the treatment of schizophrenia or bipolar I disorder AND The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone or aripiprazole. Bipolar 1 Disorder (Bipolar Depression): The member must have a diagnosis of bipolar 1 disorder (bipolar depression) and the member must have documentation of prior treatment, intolerance, or contraindication to quetiapine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

VYNDAMAX

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Left Ventricular Assist Device (LVAD), Current Pregnancy. Reauthorization: Member has evidence of slowing of clinical decline (e.g., decrease in number of hospitalizations, improvement or stabilization of the 6-minute walk test, stable or improvement in KCCQ-OS).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	The member is being treated by a specialist (e.g. cardiologist).
Coverage Duration	Plan Year Duration
Other Criteria	

VYNDAQEL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Left Ventricular Assist Device (LVAD), Current Pregnancy. Reauthorization: Member has evidence of slowing of clinical decline (e.g., decrease in number of hospitalizations, improvement or stabilization of the 6-minute walk test, stable or improvement in KCCQ-OS).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	The member is being treated by a specialist (e.g. cardiologist).
Coverage Duration	Plan Year Duration
Other Criteria	

WELIREG

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Welireg (belzutifan).
Required Medical Information	von Hippel Lindau VHL disease: The member has von Hippel Lindau (VHL) disease and the member does not require immediate surgery and The member requires treatment for: associated renal cell carcinoma (RCC) OR associated central nervous system hemangioblastomas OR pancreatic neuroendocrine tumors and Welireg (belzutifan) is administered as monotherapy. Reauthorization criteria: Physician attestation that the member has continued to receive a clinical benefit (e.g., response of lesions by imaging).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 6 months duration. Reauthorization: plan year duration.
Other Criteria	

XALKORI

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members using Xalkori (crizotinib) for adjuvant therapy.
Required Medical Information	Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) and The member will be using Xalkori (crizotinib) as monotherapy and one of the following applies: The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease AND the member has a medical reason as to why Alecensa (alectinib) or Alunbrig (brigatinib) cannot be started or continued OR the member has disease which is ROS1 positive. Anaplastic large cell lymphoma (ALCL): The member has a diagnosis of relapsed or refractory, systemic ALCL AND the disease has documented ALK-positivity AND Xalkori (crizotinib) is given as monotherapy. Inflammatory myofibroblastic tumor (IMT): the member has a diagnosis of unresectable, recurrent, or refractory IMT AND the disease has documented ALK-positivity AND Xalkori (crizotinib) is given as monotherapy.
Age Restriction	ALCL: The member is greater than 1 year of age up to young adult (21 years of age). IMT: The member is greater than 1 year of age and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	

XATMEP

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that are pregnant or nursing. Members with disease progression on Xatmep (methotrexate)(applies to acute lymphoblastic leukemia only).
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Xatmep (methotrexate) as part of a multi-phase, combination chemotherapy maintenance regimen AND The member has had previous treatment or intolerance to generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA): The member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) AND The member has had an insufficient therapeutic response to previous treatment, or is intolerant to, an adequate trial of first-line therapy including non-steroidal antiinflammatory agents (NSAIDs) AND The member has had previous treatment or intolerance to generic methotrexate.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Partial-Onset Seizures. The member has a diagnosis of partial-onset seizures AND The member has been unable to achieve seizure control with at least TWO other antiepileptic medications indicated for partial-onset seizures.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Uncorrected Pre-existing hypocalcemia. Concurrent use of bisphosphonate therapy (e.g., zoledronic acid, pamidronate)
Required Medical Information	Osteolytic Bone Metastases of Solid Tumors. The member has a diagnosis of solid tumor cancer (such as breast cancer, prostate cancer, or other solid tumor). The member must have documented bone metastases. The member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid or pamidronate (disease progression, intolerance or contraindication following treatment with pamidronate or zoledronic acid does not apply for prostate cancer). Multiple Myeloma: The member has a diagnosis of multiple myeloma AND the member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid or pamidronate. Giant Cell tumor of Bone: Diagnosis of giant cell tumor of bone. Hypercalcemia of malignancy: The member has hypercalcemia of malignancy, defined as an albumin-corrected calcium of greater than 12.5 mg/dL AND The member has had prior therapy with intravenous bisphosphonate therapy (e.g. pamidronate or zoledronic acid). Applies only to beneficiaries enrolled in an MA-PD plan. Part B before Part D Step therapy
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	

XIFAXAN

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prevention of traveler's diarrhea. Treatment of traveler's diarrhea caused by pathogens other than E.Coli. Treatement of traveler's diarrha complicated by fever or bloody stools.
Required Medical Information	Travelers diarrhea: Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli. Member has previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, or azithromycin. Hepatic encepalopathy prophylaxis: Member must have hepatic encephalpathy. Member has previous treatment, intolerance or contraindication to lactulose or neomycin. Irritable bowel syndrome with diarrhea (IBS-D): Diagnosis of Irritable bowel syndrome with diarrhea (IBS-D).
Age Restriction	Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D.
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan year for Hepatic Encepalopathy,30 days for traveler's diarrhea and 3 months for IBS-D.
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Chronic Idiopathic Urticaria. Member has a diagnosis of chronic idiopathic urticaria. Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated. Member will continue to receive H1 antihistamine therapy while on Xolair,unless contraindicated. Diagnosis of moderate or severe persistent asthma, FEV1, allergic sensitivity skin or blood test, baseline serium IgE. Omalizumab may be considered medically necessary when the following criteria are met for the following indication: Moderate or Severe persistent asthma. The patient has a diagnosis of moderate or severe persistent asthma.The patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial aeroallergen. For ages 12 and older, patient must have a baseline serum IgE between 30 IU/ml and 700 IU/ml. For ages 6 years old to less than 12 years old: must have baseline serum IgE between 30 IU/ml and 1300 IU/ml. The patient has inadequately controlled asthma despite the use of: Inhaled Corticosteroids.
Age Restriction	The patient is 12 years of age or older for diagnosis of chronic idiopathic urticaria. The patient is 6 years of age or older for moderate to severe persistent asthma. The patient is 18 years of age or older for nasal polyps.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

XOLAIR

Other Criteria	Continuation of therapy: Member is currently stable on Xolair therapy. Member will continue on asthma controller inhalers: inhaled corticosteroids with or without a long-acting beta2-agonist (e.g. Flovent HFA/Diskus, Arnuity Ellipta, Serevent Diskus, Striverdi Respimat, Advair Diskus, Breo Ellipta, Symbicrt HFA, Dulera HFA, Asmanex HFA, Asmanex Twisthaler or available generic versions of these agents). Nasal Polyps - Initial Review: The member must meet all of the following criteria: have a diagnosis of nasal polyps (e.g., Chronic Rhinosinusitis with Nasal Polyposis [CRSwNP]) AND Xolair will be used in combination with a daily intranasal corticosteroid spray AND is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Reauthorization: The member must meet ALL of the following criteria: Had a sustained improvement in symptoms (e.g., decrease in nasal congestion, decrease in polyp size, improvement in ability to smell) AND will continue intranasal corticosteroid spray therapy.

XOSPATA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on FLT3 inhibitors.
Required Medical Information	Acute Myeloid Leukemia. The member has a diagnosis of acute myeloid leukemia AND The member has relapsed or refractory disease AND The member has documented FLT3 mutation positive disease AND The member will be using Xospata (gilteritinib) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA

XPOVIO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on Xpovio (selinexor).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has received at least one prior therapy AND The member will be using Xpovio in combination with dexamethasone and bortezomib (unless documented intolerance/contraindication to corticosteroid) OR The member has a diagnosis of multiple myeloma AND The member has received at least four prior therapies AND The member's disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents and an anti-CD38 monoclonal antibody AND The member will be using Xpovio (selinexor) in combination with dexamethasone (unless documented intolerance/contraindication to corticosteroid). Diffuse large B-cell lymphoma: The member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma AND The member has received at least two prior lines of systemic therapy AND The member will be using Xpovio (selinexor) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

XTANDI

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant use with Erleada (apalutamide), abiraterone acetate,Provenge(sipuleucel-T),Taxotere(docetaxel)or Jevtana (cabazitaxel)is not recommended at this time due to lack of evidence supporting safety and efficacy. Members that have experienced disease progression while on Xtandi (enzalutamide).
Required Medical Information	Prostate Cancer (metastatic castration-resistant). The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC). Prostate Cancer (non-metastatic castration-resistant). The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND The member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog). Prostate Cancer (metastatic castration-sensitive): the member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

XYREM

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Narcolepsy with Cataplexy: The member has a diagnosis of narcolepsy with cataplexy. Reauthorization: Documentation must be provided demonstrating a reduction in frequency of cataplexy attacks associated with Xyrem therapy. Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND the member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND previous treatment, intolerance, or contraindication to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release, or dextroamphetamine) and modafinil. Prerequisite therapy required only for diagnosis of narcolepsy with excessive daytime sleepiness. Reauthorization: Documentation must be provided demonstrating a reduction in symptoms of EDS associated with Xyrem therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 3 months. Reauthorization: 6 months.
Other Criteria	NA

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with filgrastim, biosimilar filgrastim (e.g. filgrastim-sndz or filgrastim-aafi), tbo-filgrastim, sargramostim (unless part of stem cell mobilization protocol), pegfilgrastim (within seven days of pegfilgrastim dose), or biosimiliar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose).
Required Medical Information	Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia AND biosimilar filgrastim must be used in adjunct with appropriate antibiotics in high risk members. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy: The member must have a diagnosis of non-myeloid malignancy (e.g. breast cancer, lung cancer) AND The member has received or will receive myelosuppressive chemotherapy during the 24-72 hour time frame prior to starting biosimilar filgrastim injections AND The member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy AND The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) of greater than 20% based on current chemotherapy regimen (as listed in current ASCO and NCCN guidelines for myeloid growth factors) OR A risk of febrile neutropenia of 10-20% based on chemotherapy regimen and one or more of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia (defined as neutrophil count less than 500 neutrophils/mcL or less than 1,000 neutrophils/mcL and a predicted decline to less than or equal to 500 neutrophils/mcL over next 48 hours), Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication or dose-limiting neutropenic event from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR As secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 Months Duration

Other Criteria	Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation Chemotherapy AND the member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following Hematopoietic Stem Cell Transplant (HCST): The member must have had a Hematopoietic Stem Cell Transplant (HCST) (e.g. bone marrow transplant, peripheral-blood progenitor cell (PBPC) transplant) for a non-myeloid malignancy AND the member is not administering biosimilar filgrastim earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, storing cells for a possible future autologous transplant, or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in AIDS patients. The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia. The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis.The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome. The member has been acutely exposed to myelosuppressive doses of radiation.

ZEJULA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
Required Medical Information	Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer : The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum reigmen AND The member will utilize Zejula (niraparib) as a monotherapy. *Discontinue Avastin before initiating maintenance therapy with Zejula. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer - Fourth Line Treatment: The member has a diagnosis of advanced ovarian, fallopian tube, or primary peritoneal cancer AND the member's disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation OR genomic instability and progression more than six months after response to last platinum-based chemotherapy. AND the member has been treated with three or more prior lines of chemotherapy. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer – First line maintenance therapy: member has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer AND member is in complete response or partial response to first line treatment with platinum based chemotherapy AND member will utilize Zejula (niraparib) capsules as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA

ZELBORAF

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Tafinlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Zelboraf (vemurafenib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)].
Required Medical Information	Melanoma: The member has a diagnosis of Unresectable or Stage IV Metastatic melanoma.The member has a documented BRAF V600 activating mutation.The member will be using Zelboraf (vemurafenib) as monotherapy OR in combination with Cotellic (cobimetnib). Erdheim-Chester Disease: The member has a diagnosis of Erdheim-Chester Disease AND The member has a documented BRAF V600 mutation AND The member will be using Zelboraf (vemurafenib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	

ZOKINVY

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Progeroid Laminopathies: Member must meet ALL of the following criteria: Diagnosis of one of the following: Hutchinson-Gilford Progeria syndrome OR Progeroid Laminopathies with either Heterozygous LMNA mutation with progerin-like protein accumulation OR Homozygous or Compound Heterozygous ZMPTSTE24 mutations. AND Body Surface Area of 0.39 meters squared or greater.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

zoledronic acid-mannitol-water

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Severe renal impairment (creatinine clearance less than 35 mL/min). Evidence of acute renal failure.Patients with Hypocalcemia.
Required Medical Information	Osteoporosis: The member has a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Osteoporosis Prophylaxis in postmenopausal members: The member is postmenopausal. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Glucocorticoid induced Osteoporosis in men and women taking systemic glucocorticoids: Diagnosis of glucocorticoid induced osteoporosis or is either initiating or continuing systemic glucocorticoids with a daily dosage equivalent of 7.5 mg or greater of prednisone and is expected to remain on glucocorticoids for at least 12 months AND has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, IBANDRONATE, PAMIDRONATE). Paget’s Disease: Diagnosis of Paget’s disease. The member has continued elevation(s) in serum alkaline phosphatase (SAP) of two times or higher than the upper limit of normal despite previous treatment, contraindication, or intolerance with an oral OR IV bisphosphonate (ALENDRONATE, PAMIDRONATE). And the member: Is symptomatic OR is at risk for complications from their disease, to induce remission, or to normalize serum alkaline phosphatase. Brand Reclast request only: Members must have previous treatment, contraindication, or intolerance to generic Zoledronic acid (generic Reclast).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ZOLINZA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on Zolinza (vorinostat).
Required Medical Information	Cutaneous T-Cell Lymphoma (CTCL).The member has a diagnosis of progressive, persistent, or recurrent disease or The member hwill be using Zolinza as primary treatment or adjuvant therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ZONISADE

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review

ZTALMY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Seizures associated with Cyclin-dependent Kinase-Like 5 (CDKL5) Deficiency Disorder (CDD): the member has a diagnosis of cyclin-dependent kinase-like 5 CDKL5) deficiency disorder (CDD) AND the member continues to experience seizures while on current therapy AND the member has previous treatment, contraindication, or intolerance to at least one broad-spectrum antiepileptic medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

ZULRESSO

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Partum Depression: The member is an adult with a clinical diagnosis of major depressive disorder (MDD) in the third trimester of pregnancy or within 4 weeks of delivery as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. HAM-D, MADRS, PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item). The member has previous treatment, contraindication, or intolerance to at least one antidepressant from the following: generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline), SNRI (e.g., venlafaxine or duloxetine), buproprion OR mirtazapine OR physician attests with documentation that the severity of the depression would place the health of the mother or infant at significant risk. The member is not pregnant and not more than 6 months post-partum at initiation of Zulresso (brexanolone) therapy. The member is not experiencing active psychosis and does not have a history of bipolar disorders, schizophrenia, and/or schizoaffective disorder. The member has not attempted suicide in the current episode of postpartum depression.
Age Restriction	The member is at least 15 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	60 days duration
Other Criteria	

ZYDELIG

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL): The member must have a diagnosis of relapsed OR refractory chronic lymphocytic leukemia (CLL) or relapsed OR refractory small lymphocytic lymphoma (SLL). Follicular Lymphoma (FL): The member must have a diagnosis of relapsed follicular lymphoma (FL) AND The member must have received at least one prior systemic therapy AND The member will be using Zydelig (idelalisib) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA

ZYKADIA

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic and documented anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) AND the member has a medical reason as to why Alecensa (alectinib) OR Alunbrig (brigatinib) cannot be started or continued AND member will be using Zykadia (ceritinib) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PART B VERSUS PART D

Products Affected

- Akynzeo (netupitant) 300 mg-0.5 mg capsule
- Anzemet 50 MG; tablet
- aprepitant 125 mg (1)-80 mg (2) capsules in a dose pack
- aprepitant 125 MG; 125 mg (1)- 80 MG (2); 40 MG; 80 MG; capsule
- Astagraf XL 0.5 MG; 1 MG; 5 MG; capsule,extended release
- Azasan 100 MG; 75 MG; tablet
- azathioprine 100 MG; 50 MG; 75 MG; tablet
- CellCept 200 MG/ML; 250 MG; 500 MG; capsule
- CellCept 200 MG/ML; 250 MG; 500 MG; oral suspension
- CellCept 200 MG/ML; 250 MG; 500 MG; tablet
- CellCept Intravenous 500 MG; intravenous solution
- chlorpromazine 10 MG; 25 MG; tablet
- Compazine 10 MG; 5 MG; tablet
- cyclosporine 100 MG; 25 MG; capsule
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; capsule
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; oral solution
- dronabinol 10 MG; 2.5 MG; 5 MG; capsule
- Emend 125 mg (1)- 80 MG (2); 125 mg (25 mg/ ML FINAL CONC.); 40 MG; 80 MG; capsule
- Emend 125 mg (1)-80 mg (2) capsules in a dose pack
- Emend 125 mg (25 mg/mL final conc.) oral suspension
- Envarsus XR 0.75 MG; 1 MG; 4 MG; tablet,extended release
- everolimus (immunosuppressive) 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet
- Gengraf 100 MG; 100 MG/ML; 25 MG; capsule
- Gengraf 100 MG; 100 MG/ML; 25 MG; oral solution
- granisetron HCl 1 MG; tablet
- Imuran 50 MG; tablet
- Marinol 10 MG; 2.5 MG; 5 MG; capsule
- Medrol 16 MG; 2 MG; 32 MG; 4 MG; 8 MG; tablet
- methotrexate sodium 2.5 MG; tablet
- methylprednisolone 16 MG; 32 MG; 4 MG; 8 MG; tablet
- Millipred 5 MG; tablet
- mycophenolate 500 MG; intravenous solution
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; capsule
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; oral suspension
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; tablet
- mycophenolate sodium 180 MG; 360 MG; tablet,delayed release

- Myfortic 180 MG; 360 MG; tablet,delayed release
- Neoral 100 MG; 100 MG/ML; 25 MG; oral solution
- ondansetron HCl 4 MG; 4 MG/5 ML; 8 MG; oral solution
- prednisone 1 MG; 10 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; oral solution
- Prednisone Intensol 5 MG/ML; oral concentrate
- Prograf 0.2 MG; 0.5 MG; 1 MG; 5 MG; capsule
- Rapamune 0.5 MG; 1 MG; 1 MG/ML; 2 MG; oral solution
- Rayos 1 MG; 2 MG; 5 MG; tablet,delayed release
- Sandimmune 100 MG; 100 MG/ML; 25 MG; oral solution
- sirolimus 0.5 MG; 1 MG; 1 MG/ML; 2 MG; tablet
- tacrolimus 0.5 MG; 1 MG; 5 MG; capsule, immediate-release
- Trexall 10 MG; 15 MG; 5 MG; 7.5 MG; tablet
- Varubi 90 MG; tablet
- Zofran 4 MG; tablet
- Zuplenz 4 MG; 8 MG; oral soluble film
- Neoral 100 MG; 100 MG/ML; 25 MG; capsule
- ondansetron 4 MG; 8 MG; disintegrating tablet
- ondansetron HCl 4 MG; 4 MG/5 ML; 8 MG; tablet
- prednisone 1 MG; 10 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; tablet
- prochlorperazine maleate 10 MG; 5 MG; tablet
- Prograf 0.2 MG; 0.5 MG; 1 MG; 5 MG; oral granules in packet
- Rapamune 0.5 MG; 1 MG; 1 MG/ML; 2 MG; tablet
- Sandimmune 100 MG; 100 MG/ML; 25 MG; capsule
- sirolimus 0.5 MG; 1 MG; 1 MG/ML; 2 MG; oral solution
- Syndros 5 MG/ML; oral solution
- Tigan 300 MG; capsule
- trimethobenzamide 300 MG; capsule
- Xatmep 2.5 MG/ML; oral solution
- Zortress 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet

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