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Prior Authorization Criteria

Effective 11/01/2024

**abiraterone - TABLET**

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	mCRPR: 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. mCSPC: 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, or Jevtan.
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 OR Node-positive (any T, N1) OR localized disease with high risk features 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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

# abiraterone - TABLET

Other Criteria	
Part B Prerequisite	

## acitretin - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Part B Prerequisite	

## ACTIMMUNE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## acyclovir - OINTMENT (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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 two of the following: oral acyclovir, valacyclovir or famciclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## ADEMPAS - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	NA
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## AIMOVIG AUTOINJECTOR - AUTO-INJECTOR (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Migraine Prevention. Utilizing Aimovig (erenumab) for the preventative treatment of migraines AND has less than a 50% reduction in migraine headache days per month (i.e., inadequate response) after previous treatment with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol OR has intolerance or contraindication with ALL of the following oral preventive medications: Divalproex, Topiramate, Metoprolol, Propranolol, and Timolol.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## AKEEGA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
<b>Required Medical Information</b>	Prostate Cancer: Member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND Member has documented deleterious or suspected deleterious BRCA-mutated (BRCAm) disease AND Member will use in combination with prednisone or prednisolone AND Member will use Akeega (niraparib and abiraterone acetate) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## ALECENSA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on Alecensa (alectinib). Non-Small Cell Lung Cancer (Adjuvant): The member exceeds two years of total Alecensa (alectinib) treatment.
<b>Required Medical Information</b>	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. Non-small Cell Lung Cancer (Ajuvant): The member has a diagnosis of non-small cell lung cancer (NSCLC) [i.e., tumors greater than or equal to 4 cm or node positive] AND The member will be using Alecensa (alectinib) for adjuvant treatment following complete tumor resection AND The member has documented anaplastic lymphoma kinase (ALK)-positive disease AND The member will be using Alecensa (alectinib) as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## alosetron - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of severe diarrhea-predominant irritable bowel syndrome, AND The member has chronic IBS symptoms (lasting 6 months or longer), AND The member has had previous treatment, intolerance, or contraindication to one antidiarrheal agent (e.g. loperamide) AND one tricyclic antidepressant (TCA) (e.g. amitriptyline, nortriptyline, imipramine HCl, desipramine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## ALUNBRIG - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members experience disease progression on Alunbrig (brigatinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six month duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## alyq - TABLET

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
Part B Prerequisite	

## ambrisentan - TABLET

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

## APTIOM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member will not use Aptiom (eslicarbazepine) in combination with oxcarbazepine AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## ARCALYST - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome: The member has a diagnosis of Cryopyrin-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).</p>
<b>Age Restriction</b>	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.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## asenapine maleate - TABLET, SUBLINGUAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
<b>Required Medical Information</b>	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, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## AUGTYRO - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>ROS1 Positive NSCLC: Member has diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND Member has disease which is ROS-1 rearrangement(s) positive AND Member will be using Augtyro (repotrectinib) as monotherapy. NTRK Gene Fusion-Positive Solid Tumors: The member has a diagnosis of solid tumors which are metastatic OR the member is not a candidate for surgical resection AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion AND The members disease has progressed following treatment or does not have satisfactory alternative therapy options AND Member will be using Augtyro (repotrectinib) as monotherapy.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# AUSTEDO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR 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) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## AUSTEDO XR - TABLET, EXTENDED RELEASE 24 HR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR 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) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# AUSTEDO XR TITRATION KT(WK1-4) - TABLET, EXTENDED RELEASE 24 HR DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR 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) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## AUVELITY - TABLET,IMMED, EXTENDED RELEASE, BIPHASIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Major Depressive Disorder: The member has 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) AND the member has had prior therapy, contraindication, or intolerance to at least two different antidepressants of adequate dose (i.e. as determined by the treating provider based on individual patient characteristics) and duration (i.e. at least 8 weeks for each antidepressant) from the following: generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline), SNRI (e.g., venlafaxine or duloxetine), bupropion OR mirtazapine.
<b>Age Restriction</b>	The member is 18 years of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## AYVAKIT - TABLET

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 10 <sup>9</sup> /L AND Ayvakit (avapritinib) is administered as monotherapy. Indolent Systemic Mastocytosis (ISM). The member has a diagnosis of Indolent Systemic Mastocytosis (ISM) AND is not recommended for treatment of members with documented platelet counts of less than 50 X 10 <sup>9</sup> /L AND Ayvakit (avapritinib) is administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	

# BALVERSA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial carcinoma AND the member has identification of a susceptible FGFR3 genetic alteration documented in the medical record [e.g., FGFR3 gene mutations (R248C, S249C, G370C, Y373C), FGFR3 gene fusions (FGFR3-TACC3v1, FGFR3-TACCv3, FGFR3-TACC3, FGFR3-BAIAP2L1)] 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 systemic therapy, including a PD-1 (Programmed cell death protein 1) or PD-L1 (Programmed death-ligand 1) inhibitor [e.g., avelumab, pembrolizumab] (if eligible).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## BENLYSTA - AUTO-INJECTOR (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Severe active central nervous system lupus.
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	Lupus Nephritis: The member is 5 years of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## BESREMI - SYRINGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members with hepatic decompensation (Child-Pugh score greater than 6 [class B and C]). Members that have experienced disease progression while on Besremi (ropeginterferon alfa-2b-njft). Members with existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation or suicide attempt. Members that are immunosuppressed transplant recipients. Members with Hypersensitivity to interferon or to any component of Besremi (ropeginterferon alfa-2b-njft). Members with history or presence of active serious or untreated autoimmune disease.
<b>Required Medical Information</b>	Polycythemia Vera: The member has a diagnosis of Polycythemia Vera.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# BETASERON - KIT

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
Part B Prerequisite	

## bexarotene - GEL (GRAM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that are pregnant.
<b>Required Medical Information</b>	Cutaneous T-cell Lymphoma (CTCL). (bexarotene capsules). The member will be using bexarotene 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. (bexarotene 1% topical gel/jelly). The member will be using bexarotene as primary treatment OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# BOSULIF - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Bosulif (bosutinib). The member has one of the following mutations: T315I, V299L, G250E, or F317L.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# BRAFTOVI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
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 colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab). Metastatic non-small cell lung cancer: The member has documented BRAF V600E metastatic non-small cell lung cancer (NSCLC) AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month durations or as determined through clinical review
Other Criteria	
Part B Prerequisite	

# BRIVIACT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with levetiracetam AND at least one other drug for controlling partial-onset seizures (e.g. topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# BRUKINSA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Brukinsa (zanubrutinib).
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 (zanubrutinib) 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 will be using Brukinsa (zanubrutinib) as monotherapy. Waldenstroms Macroglobulinemia: The member has a diagnosis of Waldenstroms macroglobulinemia (WM) AND the member will be using Brukinsa (zanubrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Follicular Lymphoma: The member has a diagnosis of relapsed or refractory follicular lymphoma AND the member has had 2 or more previous lines of systemic therapy AND Brukinsa (zanubrutinib) will be used in combination with obinutuzumab.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## budesonide - TABLET, DELAYED AND EXTENDED RELEASE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Mild to moderate active ulcerative colitis: The member must have a diagnosis of mild to moderate active ulcerative colitis AND the member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## buprenorphine - PATCH, TRANSDERMAL WEEKLY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## CABLIVI - KIT

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 immunosuppressive 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
Part B Prerequisite	

# CABOMETYX - TABLET

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on cabozantinib.
<b>Required Medical Information</b>	Renal cell carcinoma: The member has advanced renal cell carcinoma AND one of the following applies: the member will be using Cabometyx (cabozantinib) as monotherapy OR the member will be using Cabometyx (cabozantinib) 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.
<b>Age Restriction</b>	Thyroid Cancer: Member is 12 years of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## calcipotriene - CREAM (GRAM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Psoriasis: The member must have a diagnosis of plaque psoriasis AND has had previous treatment, contraindication or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## CALQUENCE - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	The member has experienced disease progression while on or following Calquence (acalabrutinib).
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## CALQUENCE (ACALABRUTINIB MAL) - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	The member has experienced disease progression while on or following Calquence (acalabrutinib).
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## CAMZYOS - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Obstructive Hypertrophic Cardiomyopathy: member must have diagnosis of hypertrophic cardiomyopathy AND the member must have confirmation of an obstruction (e.g. cardiac MRI, echocardiogram, or cardiac catheterization) AND the member must have NYHA Class II-III symptoms AND the member must have a left ventricular ejection fraction (LVEF) of greater than or equal to 55% AND the member has had previous treatment, intolerance or contraindication to beta-blockers (e.g. atenolol, metoprolol, bisoprolol) or non-dihydropyridine calcium channel blockers (e.g. verapamil, diltiazem) at doses appropriate for obstructive hypertrophic cardiomyopathy. Reauthorization criteria: the member must meet all of the following criteria: the member must have a LVEF greater than or equal to 50% AND the member has had clinically significant improvement of symptoms (e.g. improvement in NT-proBNP, decreased shortness of breath, improvement in patient reported outcomes assessment) AND provider attestation that the patient has not and will not receive septal reduction therapy (SRT) while on mavacamten therapy.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Initial Duration: 6 Months. Reauthorization: Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## CAPLYTA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
<b>Required Medical Information</b>	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, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I or II Disorder (Bipolar 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: olanzapine, or lurasidone.
<b>Age Restriction</b>	The member must be 18 years of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## CAPRELSA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Vandetanib.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	3 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## carglumic acid - TABLET, DISPERSIBLE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Acute or chronic hyperammonemia due to NAGS deficiency: 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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## CAYSTON - VIAL, NEBULIZER (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 75% predicted. Patients colonized with Burkholderia cepacia.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# CERDELGA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## CEREZYME - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	NA
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

# CHOLBAM - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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. 3beta-hydroxy- delta5-C27-steroid oxidoreductase (3beta-HSD) deficiency, delta4-3-oxosteroid 5beta-reductase (AKR1D1) deficiency, cerebrotendinous xanthomatosis (CTX), or 2-[or alpha-] 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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## CHORIONIC GONADOTROPIN, HUMAN - VIAL (EA)

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

## clobazam - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND clobazam will be used in combination with at least one other drug for controlling seizures.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## clozapine - TABLET,DISINTEGRATING

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## COBENFY - CAPSULE

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
Part B Prerequisite	Pending CMS Review

## COBENFY STARTER PACK - CAPSULE, DOSE PACK

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
Part B Prerequisite	Pending CMS Review

# COMETRIQ - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on Cometriq (cabozantinib).
<b>Required Medical Information</b>	Metastatic Medullary Thyroid Carcinoma. The member has a diagnosis of progressive, metastatic medullary thyroid carcinoma MTC.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	six month duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## COPAXONE - SYRINGE (ML)

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
Part B Prerequisite	

## COPIKTRA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib, duvelisib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# CORLANOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Heart rate maintained exclusively by pacemaker.
Required Medical Information	<p>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.</p> <p>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.</p>
Age Restriction	
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 (ivabradine) treatment.

# CORLANOR - TABLET

Part B Prerequisite	
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## COSENTYX - SYRINGE (ML)

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, 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). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: 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	
Part B Prerequisite	

## COSENTYX (2 SYRINGES) - SYRINGE (ML)

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, 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). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: 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	
Part B Prerequisite	

## COSENTYX PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.</p>
Age Restriction	<p>Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: 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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## COSENTYX PEN (2 PENS) - PEN INJECTOR (ML)

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, 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). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: 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	
Part B Prerequisite	

## COSENTYX UNOREADY PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.</p>
Age Restriction	<p>Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: 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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## COTELLIC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Melanoma indication only: 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). Histiocytic Neoplasms: the member has a diagnosis of histiocytic neoplasms AND the member will be using Cotellic (cobimetinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

## CYLTEZO(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## CYLTEZO(CF) - SYRINGE KIT (EA)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	



## CYLTEZO(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## CYLTEZO(CF) PEN - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## CYLTEZO(CF) PEN CROHN'S-UC-HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# CYLTEZO(CF) PEN CROHN'S-UC-HS - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## CYLTEZO(CF) PEN PSORIASIS-UV - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# CYLTEZO(CF) PEN PSORIASIS-UV - PEN INJECTOR KIT (EA)

<p><b>Other Criteria</b></p>	<p>Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).</p>
<p><b>Part B Prerequisite</b></p>	

## CYSTARAN - DROPS

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
Part B Prerequisite	

## dalfampridine - TABLET, EXTENDED RELEASE 12 HR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	History of seizure disorder. Moderate to severe renal impairment (CrCl 50ml/min or less).
<b>Required Medical Information</b>	Multiple Sclerosis: Member has a diagnosis of multiple sclerosis AND Patient must be ambulatory AND The member has evidence of significant walking impairment related to multiple sclerosis.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## dasatinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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 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. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive) and Sprycel (dasatinib) 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 (dasatinib) in combination with chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## DAURISMO - TABLET

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
Part B Prerequisite	

## deferasirox - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has platelet counts less 50,000.
<b>Required Medical Information</b>	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 (for new starts only) AND The member has a serum ferritin greater than 300 mcg/L.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## DIACOMIT - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of seizures associated with Dravet syndrome AND Diacomit is prescribed by or in consultation with a specialist (i.e. neurologist, 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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## dihydroergotamine - AEROSOL, SPRAY WITH PUMP (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## dimethyl fumarate - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

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
Part B Prerequisite	

# DRIZALMA SPRINKLE - CAPSULE, DELAYED RELEASE SPRINKLE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 20mg, 30mg or 60 mg (generic Cymbalta). 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 20mg, 30mg or 60 mg (generic Cymbalta).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# DUAVEE - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## DUPIXENT PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Atopic Dermatitis: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/gel/ointment, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (e.g. tacrolimus). Eosinophilic Esophagitis (EoE): Member must meet all of the following criteria: 15 kg (33 pounds) or higher, Diagnosis of eosinophilic esophagitis (EOE) identified by endoscopic biopsy with evidence of peak cell count of greater than or equal to 15 eosinophils per high power field in 2 or more biopsied esophageal regions, two or more episodes of dysphagia per week, unable to achieve adequate control of symptoms with one guideline directed therapy (e.g., generic high dose proton pump inhibitor OR topical corticosteroid).</p>
Age Restriction	<p>Atopic dermatitis: The member must be 6 months of age or older. Chronic rhinosinusitis with nasal polyposis, Prurigo Nodularis: The member must be 18 years of age or older. Eosinophilic Esophagitis: 1 year of age or older.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## DUPIXENT PEN - PEN INJECTOR (ML)

<b>Other Criteria</b>	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma: The member has a diagnosis of moderate-to-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/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Chronic Rhinosinusitis with Nasal Polyposis: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Prurigo Nodularis: member must meet all of the following criteria: diagnosis of Prurigo Nodularis AND prescribed by or in consultation with a dermatologist, allergist, or immunologist AND unable to achieve adequate control of symptoms with one moderate to super potent topical corticosteroid OR prescriber determines that treatment with a topical corticosteroid would be inappropriate.
<b>Part B Prerequisite</b>	

## DUPIXENT SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Atopic Dermatitis: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/gel/ointment, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (e.g. tacrolimus). Eosinophilic Esophagitis (EoE): Member must meet all of the following criteria: 15 kg (33 pounds) or higher, Diagnosis of eosinophilic esophagitis (EOE) identified by endoscopic biopsy with evidence of peak cell count of greater than or equal to 15 eosinophils per high power field in 2 or more biopsied esophageal regions, two or more episodes of dysphagia per week, unable to achieve adequate control of symptoms with one guideline directed therapy (e.g., generic high dose proton pump inhibitor OR topical corticosteroid).</p>
Age Restriction	<p>Atopic dermatitis: The member must be 6 months of age or older. Chronic rhinosinusitis with nasal polyposis, Prurigo Nodularis: The member must be 18 years of age or older. Eosinophilic Esophagitis: 1 year of age or older.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## DUPIXENT SYRINGE - SYRINGE (ML)

<b>Other Criteria</b>	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma: The member has a diagnosis of moderate-to-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/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Chronic Rhinosinusitis with Nasal Polyposis: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Prurigo Nodularis: member must meet all of the following criteria: diagnosis of Prurigo Nodularis AND prescribed by or in consultation with a dermatologist, allergist, or immunologist AND unable to achieve adequate control of symptoms with one moderate to super potent topical corticosteroid OR prescriber determines that treatment with a topical corticosteroid would be inappropriate.
<b>Part B Prerequisite</b>	

## EGRIFTA SV - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ELELYSO - VIAL (EA)

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

## EMGALITY PEN - PEN INJECTOR (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Migraine Prevention. Utilizing Emgality (galcanezumab) for the preventative treatment of migraines AND has less than a 50% reduction in migraine headache days per month (i.e., inadequate response) after previous treatment with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol OR has intolerance or contraindication with ALL of the following oral preventive medications: Divalproex, Topiramate, Metoprolol, Propranolol, and Timolol.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## EMGALITY SYRINGE - SYRINGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Episodic Cluster Headache: The member has been diagnosed with episodic cluster headaches as defined as having at least two cluster periods lasting from 7 days to 1 year, separated by pain free remission periods lasting at least 1 month AND the member has been unable to achieve a reduction in weekly cluster headache attack frequency with a trial of verapamil.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## EMGALITY SYRINGE - SYRINGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Migraine Prevention. Utilizing Emgality (galcanezumab) for the preventative treatment of migraines AND has less than a 50% reduction in migraine headache days per month (i.e., inadequate response) after previous treatment with one of the following oral preventative medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol OR has intolerance or contraindication with ALL of the following oral preventive medications: Divalproex, Topiramate, Metoprolol, Propranolol, and Timolol.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# EMSAM - PATCH, TRANSDERMAL 24 HOURS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Major Depressive Disorder: 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ENBREL - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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. Juvenile Psoriatic Arthritis: The member must have a diagnosis of active juvenile psoriatic arthritis (JPsA) AND The member has prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, leflunomide).</p>
Age Restriction	<p>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 and Juvenile Psoriatic Arthritis.</p>
Prescriber Restriction	<p>Licensed Practitioner</p>
Coverage Duration	<p>Plan Year Duration</p>
Other Criteria	
Part B Prerequisite	

## ENBREL MINI - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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. Juvenile Psoriatic Arthritis: The member must have a diagnosis of active juvenile psoriatic arthritis (JPsA) AND The member has prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, leflunomide).</p>
Age Restriction	<p>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 and Juvenile Psoriatic Arthritis.</p>
Prescriber Restriction	<p>Licensed Practitioner</p>
Coverage Duration	<p>Plan Year Duration</p>
Other Criteria	
Part B Prerequisite	

## ENBREL SURECLICK - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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. Juvenile Psoriatic Arthritis: The member must have a diagnosis of active juvenile psoriatic arthritis (JPsA) AND The member has prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, leflunomide).</p>
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 and Juvenile Psoriatic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# ENVARUSUS XR - TABLET, EXTENDED RELEASE 24 HR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	NA
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

# EPCLUSA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Chronic Hepatitis C Virus Genotypes: The member must have a diagnosis of chronic hepatitis C (HCV). For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# EPIDIOLEX - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Dravet Syndrome: The member has a diagnosis of seizures associated with Dravet Syndrome AND Epidiolex (cannabidiol) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Dravet Syndrome (e.g. clobazam, valproic acid, topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Epidiolex (cannabidiol) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Lennox-Gastaut syndrome (e.g. topiramate, lamotrigine). Tuberous Sclerosis Complex: The member has a diagnosis of seizures associated with Tuberous Sclerosis Complex.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	



# EPRONTIA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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.</p> <p>Epilepsy Adjunctive Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use Eprontia (topiramate) in combination with at least one other drug for controlling seizures AND Member has tried or cannot use immediate-release topiramate tablet or capsule.</p> <p>Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND Member has tried or cannot use immediate release topiramate tablet or capsule.</p>
Age Restriction	<p>Migraine Prophylaxis: Member must be 12 years of age or older.</p> <p>Epilepsy indications: Member must be 2 years of age or older.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

# ERIVEDGE - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 month duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## ERLEADA - TABLET

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., 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 Erleada (apalutamide) 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 Erleada (apalutamide) 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
Part B Prerequisite	

## erlotinib - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# EULEXIN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of prostate cancer AND 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	
Part B Prerequisite	

## everolimus (antineoplastic) - TABLET

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 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 gastrointestinal or lung.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year 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 Everolimus in combination with exemestane or fulvestrant. Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND Everolimus tablets for oral solution is being used as adjunctive therapy.
Part B Prerequisite	

## EXKIVITY - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on Exkivity (mobocertinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# FANAPT - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Schizophrenia: The member must be utilizing Fanapt for treatment of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Fanapt for the treatment of bipolar I disorder (manic or mixed episode). The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## fentanyl citrate - LOZENGE ON A HANDLE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Treatment of acute or post-operative pain.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## FETZIMA - CAPSULE, EXTENDED RELEASE 24HR

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
Part B Prerequisite	

## fingolimod - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## FINTEPLA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Dravet Syndrome: The member has a diagnosis of seizures associated with Dravet Syndrome AND Fintepla (fenfluramine) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Dravet Syndrome (e.g. clobazam, valproic acid, topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Fintepla (fenfluramine) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Lennox-Gastaut syndrome (e.g. topiramate, lamotrigine).</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## FIRMAGON - VIAL (EA)

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

## FIRMAGON KIT W DILUENT SYRINGE - VIAL (EA)

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

## FORTEO - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## FOTIVDA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
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., immunoncology checkpoint inhibitors, cabozantinib, axitinib) AND Fotivda (tivozanib) is given as a single agent for subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	



## FRUZAQLA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member has had disease progression on Fruzaqla (fruquintinib).
<b>Required Medical Information</b>	Metastatic Colorectal Cancer (mCRC). Member has a diagnosis of metastatic colorectal cancer (mCRC) AND Member has been previously treated with the following: fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy AND anti-VEGF therapy (e.g., bevacizumab product) AND anti-EGFR therapy [if verified KRAS/NRAS wild-type (normal) and medically appropriate].
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## FULPHILA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
<b>Exclusion Criteria</b>	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 biosimilar 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.
<b>Required Medical Information</b>	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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
<b>Part B Prerequisite</b>	

## FYCOMPA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine). Adjunctive treatment of generalized tonic-clonic seizures: The member has a diagnosis of generalized tonic-clonic seizures AND Member will use Fycompa (perampanel) in combination with at least one other drug for controlling seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling generalized tonic-clonic seizures (e.g. lamotrigine, topiramate, carbamazepine, gabapentin, divalproex).</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# GAMUNEX-C - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), 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/mcL.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).</p>
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# GAMUNEX-C - VIAL (ML)

<p><b>Other Criteria</b></p>	<p>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, or for those whom corticosteroid therapy and splenectomy is contraindicated. 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 Lambert-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 OR the member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, 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, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.</p>
<p><b>Part B Prerequisite</b></p>	

# GATTEX 30-VIAL - KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	3 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# GATTEX ONE-VIAL - KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	3 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# GAVRETO - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on RET inhibitors (e.g., pralsetinib, selpercatinib).
<b>Required Medical Information</b>	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. 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.
<b>Age Restriction</b>	Thyroid Cancer: The member is 12 years of age and older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## gefitinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	

## GILOTRIF - TABLET

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
Part B Prerequisite	

## glatiramer - SYRINGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	NA
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## glatopa - SYRINGE (ML)

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
Part B Prerequisite	

## GLEOSTINE - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on Gleostine (lomustine).
<b>Required Medical Information</b>	Brain Tumors. The member has a diagnosis of primary or metastatic brain tumor AND one of the following applies: the member will use Gleostine (lomustine) after appropriate surgical and/or radiotherapeutic procedures OR the member has recurrent or progressive disease. Hodgkin Lymphoma. The member has a diagnosis of Hodgkin Lymphoma AND the member has disease progression following initial chemotherapy AND the member will use Gleostine (lomustine) as a component of combination chemotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## HAEGARDA - VIAL (EA)

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 that is consistent with the diagnosis provided. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH. 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	
Part B Prerequisite	

## HARVONI - TABLET

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 1,4,5 or 6 infection. HCV RNA level must be documented prior to therapy. Chronic Hepatitis C - GT1 treatment naive without cirrhosis and HCV RNA under 6 million IU/mL 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. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant, Member must have experienced recurrent HCV infection post-transplant in the allograft liver, Member must have document genotype 1, 4, 5 or 6 infection. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis, Member must have genotype 1, 4, 5 or 6 infection. 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	
Part B Prerequisite	

## HETLIOZ LQ - SUSPENSION, ORAL (FINAL DOSE FORM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz (tasimelteon) for the treatment of Non-24-Hour Sleep-Wake Disorder. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS and documented evidence of nighttime sleep disturbances associated with SMS.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## HUMIRA - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HUMIRA - SYRINGE KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

# HUMIRA PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HUMIRA PEN - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

# HUMIRA PEN CROHNS-UC-HS START - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HUMIRA PEN CROHNS-UC-HS START - PEN INJECTOR KIT (EA)

<p><b>Other Criteria</b></p>	<p>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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).</p>
<p><b>Part B Prerequisite</b></p>	

# HUMIRA PEN PSOR-UVEITS-ADOL HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HUMIRA PEN PSOR-UVEITS-ADOL HS - PEN INJECTOR KIT (EA)

<p><b>Other Criteria</b></p>	<p>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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).</p>
<p><b>Part B Prerequisite</b></p>	



## HUMIRA(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HUMIRA(CF) - SYRINGE KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HUMIRA(CF) PEDI CROHNS STARTER - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HUMIRA(CF) PEDI CROHNS STARTER - SYRINGE KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HUMIRA(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HUMIRA(CF) PEN - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HUMIRA(CF) PEN CROHNS-UC-HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HUMIRA(CF) PEN CROHNS-UC-HS - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	



## HUMIRA(CF) PEN PEDIATRIC UC - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HUMIRA(CF) PEN PEDIATRIC UC - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

# HUMIRA(CF) PEN PSOR-UV-ADOL HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HUMIRA(CF) PEN PSOR-UV-ADOL HS - PEN INJECTOR KIT (EA)

<b>Other Criteria</b>	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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HYFTOR - GEL (GRAM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## HYRIMOZ PEN CROHN'S-UC STARTER - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HYRIMOZ PEN CROHN'S-UC STARTER - PEN INJECTOR (ML)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HYRIMOZ PEN PSORIASIS STARTER - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration



# HYRIMOZ PEN PSORIASIS STARTER - PEN INJECTOR (ML)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HYRIMOZ(CF) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HYRIMOZ(CF) - SYRINGE (ML)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HYRIMOZ(CF) PEDI CROHN STARTER - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

## HYRIMOZ(CF) PEDI CROHN STARTER - SYRINGE (ML)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

## HYRIMOZ(CF) PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, 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, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). 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.</p>
Age Restriction	<p>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, Ulcerative Colitis, Hidradenitis Suppurativa, Uveitis. The member must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis. Must be six years or older for Crohns Disease.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

# HYRIMOZ(CF) PEN - PEN INJECTOR (ML)

<b>Other Criteria</b>	Ulcerative colitis: 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, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
<b>Part B Prerequisite</b>	

# IBRANCE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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 AND the member has a medical reason as to why Kisqali (ribociclib) or Verzenio (abemaciclib) cannot be started or continued as initial endocrine based therapy 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. anastrozole) 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. anastrozole) for their metastatic disease AND the member has a medical reason as to why Kisqali (ribociclib) or Verzenio (abemaciclib) cannot be started or continued as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	



## icatibant - SYRINGE (ML)

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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).
<b>Required Medical Information</b>	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 that is consistent with the diagnosis provided. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH. The member is using icatibant for treatment of acute attacks of HAE.
<b>Age Restriction</b>	The member must be 18 years or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# ICLUSIG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Iclusig (ponatinib).
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 OR Iclusig (ponatinib) will be used in combination with chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## IDHIFA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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	
Part B Prerequisite	

## imatinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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	[Pediatric] Chronic myeloid leukemia (CML) - The member is at least one year of age.
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.
Part B Prerequisite	

## IMBRUVICA - SUSPENSION, ORAL (FINAL DOSE FORM)

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 (ibrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Waldenstroms Macroglobulinemia: The member has a diagnosis of Waldenstroms 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	
Part B Prerequisite	

## INBRIJA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Parkinson's Disease "off" episodes: The member has a diagnosis of Parkinson's disease AND is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Inbrija (inhaled levodopa) AND is experiencing breakthrough "off" periods related to their Parkinson's disease.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## INCRELEX - VIAL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The bone epiphyses are closed.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# INLYTA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Inlyta (axitinib).
<b>Required Medical Information</b>	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, Hurthle 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## INQOVI - TABLET

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
Part B Prerequisite	

# INREBIC - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Inrebic (fedratinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ISTURISA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cushing's Disease: The member has a diagnosis of Cushing's disease AND The member has had an inadequate response to pituitary surgery or pituitary surgery is not an option.
Age Restriction	The member is 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	

## ivabradine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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	
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 (ivabradine) treatment.

# ivabradine - TABLET

Part B Prerequisite	
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# IWILFIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has had prior progression on Iwilfin (eflornithine). Member has been on therapy for more than two years.
Required Medical Information	High-Risk Neuroblastoma (HRNB): Member has diagnosis of high-risk neuroblastoma AND Member has had at least a partial response (or better) to prior multiagent, multimodality therapy including anti-GD2 immunotherapy (e.g., dinutuximab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## JAKAFI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Jakafi (ruxolitinib).
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. 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).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## javygtor - POWDER IN PACKET (EA)

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 tetrahydrobiopterin -(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
Part B Prerequisite	



# JAYPIRCA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Mantle cell lymphoma: The member has a diagnosis of mantle cell lymphoma AND the member has relapsed or refractory disease AND the member has received at least two prior lines of systemic therapy, including a BTK inhibitor AND the member will be using Jaypirca (pirtobrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND the member has received at least 2 prior lines of therapy, including BTK inhibitor and a BCL-2 inhibitor AND the member will be using Jaypirca (pirtobrutinib) as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## JYLAMVO - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Jylamvo (methotrexate) as part of combination chemotherapy maintenance regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Mycosis Fungoides: The member has a diagnosis of mycosis fungoides (cutaneous T-cell lymphoma) AND The member will be using Jylamvo (methotrexate) as a single agent or as part of combination chemotherapy regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Non-Hodgkin lymphomas: The member has a diagnosis of non-Hodgkin lymphoma AND The member will be using Jylamvo (methotrexate) as part of a metronomic combination chemotherapy regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Rheumatoid Arthritis: The member has a diagnosis of Rheumatoid Arthritis AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Psoriasis: The member has a diagnosis of severe psoriasis AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. B vs D coverage determination may also be required.</p>
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

# KERENDIA - TABLET

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 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	
Part B Prerequisite	

## ketoconazole - TABLET

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 immunosuppressant therapy with cyclosporine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	

# KISQALI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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 will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy 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 the member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	

# KISQALI FEMARA CO-PACK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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 will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy 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 the member will be using Kisqali (ribociclib) in combination with Faslodex (fulvestrant).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	

# KORLYM - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## KOSELUGO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	



## KRAZATI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on KRAS G12C inhibitor (e.g., sotorasib, adagrasib).
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 Krazati (adagrasib) will be given as monotherapy. Colorectal Cancer (CRC): The member has a diagnosis of locally advanced or metastatic colorectal cancer (CRC) AND the CRC has a documented KRAS G12C mutation AND the member has received prior systemic treatment with chemotherapy [fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin, irinotecan] AND Krazati (adagrasib) will be given in combination with Erbitux (cetuximab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	

## lapatinib - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Tykerb (lapatinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 month duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## LAZCLUZE - TABLET

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
Part B Prerequisite	Pending CMS Review

## lenalidomide - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on 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, 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. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year 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], 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.
Part B Prerequisite	

# LENVIMA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Lenvima (lenvatinib).
Required Medical Information	<p>Thyroid Cancer: The member has a diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (i.e. papillary carcinoma, follicular carcinoma or Hurthle 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). Hepatocellular 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 documented mismatch repair proficient (pMMR) as determined by an FDA-approved test AND The member is not a candidate for curative surgery or radiation AND The member has experienced disease progression on prior systemic therapy AND Lenvima (levatinib) 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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## leuprolide (3 month) - VIAL (EA)

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 leiomyoma. 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
Part B Prerequisite	

## **lidocaine - ADHESIVE PATCH, MEDICATED**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## LONSURF - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on Lonsurf.
<b>Required Medical Information</b>	Metastatic Colorectal Cancer: The member has a diagnosis of metastatic colorectal cancer AND The member is using Lonsurf as monotherapy or in combination with bevacizumab product 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 product) 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## LORBRENA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members experience disease progression on Lorbrena (lorlatinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# LUMAKRAS - TABLET

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 as subsequent treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

# LUPRON DEPOT - SYRINGE KIT (EA)

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 leiomyoma. 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
Part B Prerequisite	

## LUPRON DEPOT (3 MONTH) - SYRINGE KIT (EA)

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 leiomyoma. 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
Part B Prerequisite	

## LUPRON DEPOT (4 MONTH) - SYRINGE KIT (EA)

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 leiomyoma. 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
Part B Prerequisite	

## LUPRON DEPOT (6 MONTH) - SYRINGE KIT (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	Concomitant use with other LHRH agents.
<b>Required Medical Information</b>	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 leiomyoma. 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).
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## LUPRON DEPOT-PED - SYRINGE KIT (EA)

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 leiomyoma. 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
Part B Prerequisite	

## LUPRON DEPOT-PED (3 MONTH) - SYRINGE KIT (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	Concomitant use with other LHRH agents.
<b>Required Medical Information</b>	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 leiomyoma. 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).
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	



## LYBALVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use of opioids. Episode of acute opioid withdrawal.
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 generic atypical antipsychotics: olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (acute manic or mixed, maintenance monotherapy): The member must have a diagnosis of bipolar I disorder (acute manic or mixed, maintenance monotherapy) AND The member must have documentation of prior therapy, intolerance, or contraindication to at least two of the following generic atypical antipsychotics: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

# LYNPARZA - TABLET

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Breast Cancer (Metastatic): 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 as defined by and FDA approved test. 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 is in complete or partial response to their last platinum regimen AND The member will utilize Lynparza (olaparib) tablets as monotherapy. *Discontinue Bevacizumab Product before initiating maintenance therapy with Lynparza.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration

# LYNPARZA - TABLET

<p><b>Other Criteria</b></p>	<p>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 will use Lynparza (olaparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog) AND the member has one of the following: 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 OR Member has deleterious germline or suspected germline BRCA-mutated (BRCAm) disease AND Member will use in combination with abiraterone and prednisone or prednisolone. 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.</p>
<p><b>Part B Prerequisite</b></p>	

## LYTGOBI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression on Lytgobi (futibatinib)
Required Medical Information	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic intrahepatic cholangiocarcinoma (iCCA) AND The member has iCCA with documented FGFR2 gene fusions or other rearrangements AND The member has received prior treatment AND Lytgobi (futibatinib) is given as a single agent for subsequent therapy
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	

# MEKINIST - SOLUTION, RECONSTITUTED, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	<p>Melanoma - Unresectable or metastatic: 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).] Non-small cell lung cancer, Anaplastic Thyroid Cancer and Metastatic Solid Tumors: 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 prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib).] Adjuvant melanoma: member is taking Mekinist (trametinib) total treatment for more than one year. 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 prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib).] Low-grade Glioma: 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).]</p>

## MEKINIST - SOLUTION, RECONSTITUTED, ORAL

<b>Required Medical Information</b>	<p>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).</p> <p>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.</p> <p>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.</p> <p>Low-grade Glioma: The member has a diagnosis of low-grade glioma (LGG) AND The member has a documented BRAF V600E mutation AND Mekinist (trametinib) will be used in combination with Tafinlar (dabrafenib).</p>
<b>Age Restriction</b>	Low-grade Glioma only: The member is a pediatric age 1 year of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Low-grade Glioma: Plan year duration. All other indications: 6 months duration.
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# MEKTOVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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 colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) is given in combination with Erbitux (cetuximab). Metastatic non-small cell lung cancer: The member has documented BRAF V600E metastatic non-small cell lung cancer (NSCLC) AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month durations or as determined through clinical review
Other Criteria	
Part B Prerequisite	

## memantine - CAPSULE SPRINKLE, EXTENDED RELEASE 24 HR

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



## mifepristone - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## modafinil - TABLET

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
Part B Prerequisite	

## molindone - TABLET

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 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, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## MOZOBIL - VIAL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## MYALEPT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Partial lipodystrophy OR Liver disease including non-alcoholic steatohepatitis (NASH) OR HIV related lipodystrophy 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 or 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
Part B Prerequisite	

## NATPARA - CARTRIDGE (EA)

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

# NERLYNX - TABLET

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
Part B Prerequisite	

## NEULASTA - SYRINGE (ML)

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 biosimilar 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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
Part B Prerequisite	



# NEULASTA ONPRO - SYRINGE, WITH WEARABLE INJECTOR

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 biosimilar 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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
Part B Prerequisite	

# NEXLETOL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Primary Hyperlipidemia: Diagnosis of primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH]) and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR statin intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms) Cardiovascular Disease: diagnosis of: established cardiovascular disease (CVD) OR member is at high risk for a CVD event but without established CVD and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR unable to take recommended statin therapy due to statin intolerance (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms) and including those not taking a statin.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# NEXLIZET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Primary Hyperlipidemia: Diagnosis of primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH]) and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR statin intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms) Cardiovascular Disease: diagnosis of: established cardiovascular disease (CVD) OR member is at high risk for a CVD event but without established CVD and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR unable to take recommended statin therapy due to statin intolerance (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms) and including those not taking a statin.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# NINLARO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with disease progression on Ninlaro (ixazomib).
Required Medical Information	<p>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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

# NUBEQA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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). Prostate Cancer (metastatic hormone-sensitive prostate cancer): The member has a diagnosis of metastatic hormone-sensitive prostate cancer AND the member will use Nubeqa (darolutamide) in combination with docetaxel AND the member will use Nubeqa (darolutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or GnRH analog).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

# NUCALA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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/microliter at therapy initiation OR greater than or equal to 300 cells/microliter 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). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala only: 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 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/microliter.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	<p>Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: 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.</p>
Part B Prerequisite	

## NUEDEXTA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pseudobulbar Affect: The member has a diagnosis of Pseudobulbar Affect (PBA) due 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.
<b>Age Restriction</b>	Member must be 18 years of age or older
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## NUPLAZID - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	



## octreotide acetate - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	<p>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.</p>
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	

## octreotide,microspheres - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	<p>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.</p>
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	

## ODOMZO - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member has experienced disease progression while on Odomzo.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six month duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## OFEV - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## OGSIVEO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member has had disease progression on Ogsiveo (nirogacestat).
<b>Required Medical Information</b>	Desmoid tumors: Member has been diagnosed with progressing desmoid tumor (progressing desmoid tumors are defined as greater than or equal to 20% progression based on Response Evaluation Criteria in Solid Tumors [RECIST] within 12 months) AND Member will be using Ogsiveo (nirogacestat) as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## OJEMDA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member has experienced disease progression while on Ojemda (tovorafenib).
<b>Required Medical Information</b>	Pediatric Low-Grade Glioma (pLGG): The member has a diagnosis of relapsed or refractory pediatric low-grade glioma (LGG) AND The member has a documented BRAF fusion or rearrangement, or documented BRAF V600E mutation.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## OJJAARA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Ojjaara (momelotinib).
Required Medical Information	Myelofibrosis - Initial: 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 has anemia* AND The member will be using Ojjaara (momelotinib) as monotherapy AND The member has tried, intolerant to, or has a contraindication to Jakafi (Ruxolitinib) or has hemoglobin less than 8 g/dL. *Anemia is defined as hemoglobin less than 10 g/dL or having transfusion-dependent anemia. Myelofibrosis - Reauthorization: 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 auth and Reauthorization: 6 months duration
Other Criteria	
Part B Prerequisite	

## OMNITROPE - CARTRIDGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	<p>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).</p>



## OMNITROPE - CARTRIDGE (ML)

<b>Required Medical Information</b>	<p>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/m<sup>2</sup> OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m<sup>2</sup> and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m<sup>2</sup> 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/m<sup>2</sup>. 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.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration

# OMNITROPE - CARTRIDGE (ML)

<p><b>Other Criteria</b></p>	<p>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 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 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.</p>
<p><b>Part B Prerequisite</b></p>	

## ONUREG - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

# OPSUMIT - TABLET

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

# ORGOVYX - TABLET

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

## ORKAMBI - GRANULES IN PACKET (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND submission of lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ORSERDU - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Estrogen Receptor (ER)- positive Breast Cancer: The member has ER-positive, HER2-negative advanced or metastatic breast cancer AND the breast cancer has documented ESR1-mutation as determined by FDA approved test AND the member has progressive disease following at least one prior line endocrine therapy (e.g., fulvestrant, CDK 4/6 inhibitor) AND Orserdu (elacestrant) is given as single agent as subsequent therapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# OSPHENA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must be post-menopausal AND the member must have vulvar and/or vaginal atrophy AND one of the following: the member must have moderate to severe dyspareunia OR the member must have moderate to severe vaginal dryness.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	



# OTEZLA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide), or contraindication with all DMARDS. Mild Plaque Psoriasis: 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). Moderate to Severe Plaque 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. 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).</p>
Age Restriction	<p>Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease, psoriatic arthritis, and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# OTEZLA STARTER - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, leflunomide), or contraindication with all DMARDS. Mild Plaque Psoriasis: 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). Moderate to Severe Plaque 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. 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).</p>
Age Restriction	<p>Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease, psoriatic arthritis, and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## oxandrolone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Enhancement of athletic performance.
Required Medical Information	Cachexia associated with any of the following: 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	
Part B Prerequisite	

## PANRETIN - GEL (GRAM)

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
Part B Prerequisite	

## pazopanib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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, Hurthle cell carcinoma, papillary 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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# PEGASYS - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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 two of the following: Vemlidy, tenofovir disoproxil fumarate, or entecavir.</p> <p>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 two of the following: Vemlidy, tenofovir disoproxil fumarate , or entecavir.</p> <p>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 genotypes 1,4,5 or 6, The member has had previous treatment, contraindication, or intolerance to Epclusa AND Harvoni.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 to 120 week treatment course depending on the disease state and/or genotype.
Other Criteria	<p>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. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.</p>

# PEGASYS - SYRINGE (ML)

Part B Prerequisite	
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## PEMAZYRE - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experienced disease progression on Pemazyre (pemigatinib)
<b>Required Medical Information</b>	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. Relapsed or refractory myeloid/lymphoid neoplasms: the member has a diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) AND MLNs documented as fibroblast growth factor receptor 1 (FGFR1) rearrangement AND Pemazyre (pemigatinib) is being given as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## pimecrolimus - CREAM (GRAM)

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

# PIQRAY - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members have severe hypersensitivity to Piqray (alpelisib). Members has experienced disease progression on PIK3CA inhibitors (e.g., alpelisib).
<b>Required Medical Information</b>	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 (e.g., anastrozole, palbociclib) AND Piqray (alpelisib) will be given in combination with fulvestrant as subsequent therapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## pirfenidone - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Idiopathic Pulmonary Fibrosis (IPF):The member meets ALL of the following criteria: Documentation of Pulmonary Fibrosis by one of the following: computed tomography (CT) scan that is indicative of usual interstitial pneumonia (UIP) OR surgical lung biopsy AND Has not had 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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## plerixafor - VIAL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# POMALYST - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Pomalyst (pomalidomide).
Required Medical Information	<p>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, carfilzomib) 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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

## posaconazole - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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 oropharyngeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# PREVYMIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Prophylaxis (PPX) 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. Prophylaxis (PPX) of CMV disease in adult kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]). Member must have received a kidney transplant AND Member must be CMV-seronegative (R-) AND Member must have received a kidney from a CMV-seropositive (D+) donor AND Member must have a medical reason as to why valganciclovir therapy cannot be started or continued (e.g., breakthrough CMV infection, adverse effects leading to discontinuation of valganciclovir).</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 Months Duration
Other Criteria	
Part B Prerequisite	

## PROCRIT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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.</p> <p>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.</p> <p>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 than 10.0 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 prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan year duration. Reauth: Plan year duration.



# PROCRIT - VIAL (ML)

<p><b>Other Criteria</b></p>	<p>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 12.0 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 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 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). 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).</p>
<p><b>Part B Prerequisite</b></p>	

## PROMACTA - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	ITP members with previous documented failure of eltrombopag.
Required Medical Information	<p>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 10<sup>9</sup>/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 10<sup>9</sup>/L. 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 10<sup>9</sup>/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 10<sup>9</sup>/L AND The member continues to receive interferon based therapy.</p> <p>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 10<sup>9</sup>/L.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	

## PYRUKYND - TABLET, DOSE PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## QINLOCK - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	Member experiences disease progression on Qinlock (ripretinib).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## quinine sulfate - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
<b>Required Medical Information</b>	Plasmodium Falciparum Malaria: Diagnosis of uncomplicated chloroquine-resistant Plasmodium falciparum malaria.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## QULIPTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: Will be utilizing Qulipta (atogepant) for the preventative treatment of migraines AND Has been unable to achieve at least a 50% reduction in migraine headache days per month after previous treatment (of at least 2 months) with 1 of the following oral preventive medications: Divalproex, Topiramate, Metoprolol, Propranolol, or Timolol.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## rasagiline - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease: The member has a diagnosis of Parkinson's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

# REPATHA PUSHTRONEX - WEARABLE INJECTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Primary Hyperlipidemia: 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	<p>Licensed Practitioner</p>
Coverage Duration	<p>Plan Year Duration</p>



# REPATHA PUSHTRONEX - WEARABLE INJECTOR

<p><b>Other Criteria</b></p>	<p>Clinical Atherosclerotic Cardiovascular Disease (ASCVD): 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. 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.</p>
<p><b>Part B Prerequisite</b></p>	

# REPATHA SURECLICK - PEN INJECTOR (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Primary Hyperlipidemia: 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.
<b>Age Restriction</b>	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.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration

## REPATHA SURECLICK - PEN INJECTOR (ML)

<p><b>Other Criteria</b></p>	<p>Clinical Atherosclerotic Cardiovascular Disease (ASCVD): 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. 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.</p>
<p><b>Part B Prerequisite</b></p>	

# REPATHA SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Primary Hyperlipidemia: 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.</p>
Age Restriction	<p>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.</p>
Prescriber Restriction	<p>Licensed Practitioner</p>
Coverage Duration	<p>Plan Year Duration</p>

# REPATHA SYRINGE - SYRINGE (ML)

<p><b>Other Criteria</b></p>	<p>Clinical Atherosclerotic Cardiovascular Disease (ASCVD): 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. 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.</p>
<p><b>Part B Prerequisite</b></p>	

## RETACRIT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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.</p> <p>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.</p> <p>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 than 10.0 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 prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan year duration. Reauth: Plan year duration.

# RETACRIT - VIAL (ML)

<p><b>Other Criteria</b></p>	<p>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 12.0 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 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).</p>
<p><b>Part B Prerequisite</b></p>	

# RETEVMO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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. RET fusion-positive Solid Tumors: the member has locally advanced or metastatic solid tumors AND the solid tumors have documented rearranged during transfection (RET) gene fusion positive AND the member has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options AND Retevmo (selpercatinib) is being administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	



# REXULTI - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Major depressive disorder: The member has a clinical diagnosis of major depressive disorder (MDD) AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one generic oral atypical antipsychotic therapy AND Rexulti must be used as adjunctive treatment to antidepressant therapy and not as monotherapy.</p> <p>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.</p> <p>Agitation Associated with Dementia Due to Alzheimer's Disease: The member must have clinically diagnosed agitation associated with dementia due to Alzheimer's disease AND Rexulti (brexpiprazole) will not be used as a needed (prn) treatment for agitation.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## REZLIDHIA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member has experienced disease progression while on or following Rezlidhia (olutasidenib).
<b>Required Medical Information</b>	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 The member will be using Rezlidhia (olutasidenib) as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six month duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## REZUROCK - TABLET

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 systemic therapy AND the member has a medical reason as to why Jakafi (ruxolitinib) cannot be started or continued.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## RINVOQ - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Rheumatoid Arthritis: The member has a diagnosis of moderate to severely active rheumatoid arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product, Enbrel). 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. adalimumab product, 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. adalimumab product). Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product, Enbrel). Non-radiographic Axial Spondylarthritis: the member has a diagnosis of non-radiographic axial spondylarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance to one or more TNF blockers (e.g. adalimumab product). Crohn's Disease: the member has a diagnosis of moderate to severe Crohn's Disease AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product).</p>
Age Restriction	<p>RA, UC, ankylosing spondylitis, Non-radiographic axial spondylarthritis and Crohn's Disease: The member is 18 years of age or older. Atopic Dermatitis: the member is 12 years of age or older. Psoriatic arthritis and polyarticular juvenile idiopathic arthritis: the member is 2 years of age or older.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	<p>Polyarticular Juvenile Idiopathic Arthritis: The member has a diagnosis of active polyarticular juvenile idiopathic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product, Enbrel).</p>

# RINVOQ - TABLET, EXTENDED RELEASE 24 HR

Part B Prerequisite	
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# RINVOQ LQ - SOLUTION, ORAL

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, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product, Enbrel). Polyarticular Juvenile Idiopathic Arthritis: The member has a diagnosis of active polyarticular juvenile idiopathic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. adalimumab product, Enbrel).
Age Restriction	The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

# ROZLYTREK - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 OR The member is not a candidate for surgical resection AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation AND The member's disease has progressed following treatment or does not have satisfactory alternative therapy options.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## RUBRACA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula(niraparib)].
<b>Required Medical Information</b>	Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Maintenance Therapy: The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Rubraca (rucaparib) as monotherapy. *Discontinue Bevacizumab product before initiating maintenance therapy with Rubraca. 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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## rufinamide - SUSPENSION, ORAL (FINAL DOSE FORM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Patients with familial short QT syndrome.
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# RYDAPT - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	AML newly diagnosed and AML relapsed/refractory: Members that have experienced disease progression while on or following Rydapt (midostaurin), Members that are using Rydapt(midostaurin) for post-consolidation therapy. Systemic Mastocytosis: Members that have experienced disease progression while on or following Rydapt (midostaurin).
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## sajazir - SYRINGE (ML)

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 that is consistent with the diagnosis provided. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH. 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	
Part B Prerequisite	

## SANDOSTATIN LAR DEPOT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	<p>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.</p>
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	

## sapropterin - POWDER IN PACKET (EA)

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 tetrahydrobiopterin -(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
Part B Prerequisite	

## SCSEMBLIX - TABLET

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	Plan year duration
Other Criteria	
Part B Prerequisite	

## SECUADO - PATCH, TRANSDERMAL 24 HOURS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.
<b>Required Medical Information</b>	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, olanzapine, quetiapine, ziprasidone, aripiprazole, lurasidone.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## SIGNIFOR - AMPUL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cushings disease: Diagnosis of Cushings disease AND Pituitary surgery is not an option or has not been curative AND No severe hepatic impairment (Child-Pugh C).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## sildenafil (pulm.hypertension) - TABLET

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

# SIRTURO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	24 weeks duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# SKYRIZI - WEARABLE INJECTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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, leflunomide), or contraindication with all DMARDS. Moderately to severely active Crohns disease: member has a diagnosis of moderately to severely active Crohns 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). Moderately to severely active ulcerative colitis: 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, methylprednisolone) OR immunomodulators (e.g. azathioprine, 6-mercaptopurine).</p>
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## sodium oxybate - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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 sodium oxybate (generic 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) or modafinil or armodafinil. Reauthorization: Documentation must be provided demonstrating a reduction in symptoms of EDS associated with sodium oxybate (generic Xyrem) therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial authorization: 3 months. Reauthorization: 6 months.
Other Criteria	The member will be using no more than one of the following products at any given time: Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Lumryz (sodium oxybate), Sunosi (solriamfetol), or Wakix (pitolisant).
Part B Prerequisite	

## SOMATULINE DEPOT - SYRINGE (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of acromegaly. The member has a diagnosis of acromegaly. The member has had an inadequate response to or cannot be treated with traditional therapies including surgery and/or 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## SOMAVERT - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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, Somatuline depot).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## sorafenib - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Nexavar (sorafenib).
<b>Required Medical Information</b>	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 Hurthle 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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

# SPRYCEL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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 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. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive) and Sprycel (dasatinib) 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 (dasatinib) in combination with chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	



# STELARA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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 prior therapy or intolerance to one or more oral systemic treatments (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, 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). Moderate to severely active ulcerative colitis (IV and SC formulations): 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) OR immunomodulators (e.g. azathioprine, 6-mercaptopurine).</p>
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	
Part B Prerequisite	

# STIVARGA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Stivarga (regorafenib).
Required Medical Information	<p>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 experienced disease progression, intolerance, or contraindication 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*, has experienced disease progression, intolerance, or contraindication with anti-EGFR therapy (e.g., cetuximab, panitumumab). *This criteria only applies to left sided tumors.</p> <p>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.</p> <p>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 therapy (e.g., sorafenib). Soft Tissue sarcoma. Diagnosis of advanced or metastatic soft tissue sarcoma (e.g., angiosarcoma, non-adipocytic sarcoma, pleomorphic rhabdomyosarcoma) AND Stivarga (regorafenib) is being given as a single agent.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Month Duration
Other Criteria	
Part B Prerequisite	

## STRENSIQ - VIAL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## sunitinib malate - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on sunitinib. 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 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). Advanced/Metastatic Angiosarcoma. Diagnosis of diagnosis of advanced/metastatic angiosarcoma AND 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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## SYMPAZAN - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## SYNRIBO - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Synribo (omacetaxine mepesuccinate).
<b>Required Medical Information</b>	Chronic Myelogenous Leukemia. The member has a diagnosis of 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TABRECTA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on Tabrecta (capmatinib).
<b>Required Medical Information</b>	Non-Small Lung Cell Cancer (NSCLC): The member has a diagnosis of metastatic NSCLC AND the disease is documented MET exon 14 skipping positive.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## tadalafil (pulm. hypertension) - TABLET

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



## TAFINLAR - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	<p>Melanoma - Unresectable or metastatic, Anaplastic Thyroid Cancer, Metastatic Solid Tumors: 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)]. Non-small cell lung cancer: 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 prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)]. Adjuvant melanoma: member is taking Tafinlar (dabrafenib) total treatment for more than one year. 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 prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinst (trametinib)]. Low-grade Glioma: 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)].</p>

## TAFINLAR - CAPSULE

<b>Required Medical Information</b>	<p>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 (dabrafenib) 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. Low-grad Glioma: The member has a diagnosis of low-grade glioma (LGG) AND The member has a documented BRAF V600E mutation AND Tafinlar (dabrafenib) will be used in combination with Mekinist (trametinib).</p>
<b>Age Restriction</b>	Low-grade Glioma only: The member is a pediatric age 1 year of age or older.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Low-grade Glioma: Plan year duration. All other indications: 6 months duration.
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TAGRISSEO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members who have disease progression on Tagrisso (osimertinib). Total treatment exceeds three years (applicable to adjuvant therapy in NSCLC).
<b>Required Medical Information</b>	Non small cell lung cancer NSCLC: The member has a diagnosis of advanced or metastatic non small cell lung cancer (NSCLC) and ONE of 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 Tagrisso (osimertinib) is being used in combination with pemetrexed and platinum-based chemotherapy (e.g., cisplatin, carboplatin) as first-line therapy OR The member has a diagnosis of advanced or metastatic non small cell lung cancer (NSCLC) and 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 be taking (osimertinib) as a single agent for adjuvant therapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TALZENNA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members have experienced disease progression while on or following PARP inhibitor therapy (eg, olaparib).
<b>Required Medical Information</b>	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 BRCA mutated disease AND if member has hormone receptor positive disease then is endocrine refractory AND Talzenna (talazoparib) will be used as monotherapy. Metastatic Castration-Resistant Prostate Cancer (mCRPC). Member has a diagnosis of Metastatic Castration-Resistant Prostate Cancer (mCRPC) AND Member has a documented (HRR) gene-mutated disease AND Member will use Talzenna (talazoparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or concurrent GnRH analog) AND Talzenna (talazoparib) is given in combination with Xtandi (enzalutamide).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TASIGNA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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, or F359V/C/I.
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 OR Low-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The members has a diagnosis of chronic phase CML that has received previous treatment. 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	
Part B Prerequisite	

## tasimelteon - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz (tasimelteon) for the treatment of Non-24-Hour Sleep-Wake Disorder. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS and documented evidence of nighttime sleep disturbances associated with SMS.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## tazarotene - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## TAZVERIK - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member experiences disease progression on Tazverik
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Six month duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## TEPMETKO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	The member experiences disease progression on MET inhibitor (e.g., Tabrecta, Tepmetko).
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC). The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND The disease is documented MET exon 14 skipping positive.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## teriflunomide - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 clinically isolated syndrome (CIS).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## testosterone - GEL IN METERED-DOSE PUMP

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
Part B Prerequisite	

## tetrabenazine - TABLET

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

## THALOMID - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on thalidomide.
<b>Required Medical Information</b>	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. Waldenstrom's Macroglobulinemia.The member has a diagnosis of Waldenstrom'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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TIBSOVO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Tibsovo (ivosedinib).
Required Medical Information	<p>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.</p> <p>Cholangiocarcinoma: The member has locally advanced or metastatic cholangiocarcinoma AND the disease has documented isocitrate dehydrogenase-1 (IDH1) mutation AND Tibsovo (ivosedinib) will be a subsequent therapy and used as monotherapy.</p> <p>Myelodysplastic syndromes (MDS): The member has a diagnosis of myelodysplastic syndromes AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND The member will be using Tibsovo (ivosidenib) as monotherapy.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	

## tobramycin in 0.225 % nacl - AMPUL FOR NEBULIZATION (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Patients colonized with Burkholderia cepacia.
<b>Required Medical Information</b>	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. BvsD Coverage Determination may also be required.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## torpenz - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on everolimus.
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) with TSC [Adult and Pediatrics]: Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of SEGA associated with tuberous sclerosis complex (TSC) AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Angiomyolipoma and Tuberous Sclerosis Complex (TSC): Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC) AND Immediate surgery is not required. Metastatic Breast Cancer: Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative metastatic disease AND The member has been treated with endocrine therapy (e.g., letrozole, anastrozole) AND The member will use everolimus in combination with exemestane or fulvestrant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	



## tretinoin - GEL (GRAM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TRIKAFTA - TABLET, SEQUENTIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND submission of lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TRUQAP - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member has progression while on Truqap (capivasertib).
<b>Required Medical Information</b>	HR-positive/HER2-negative metastatic breast cancer. Member has metastatic or locally advanced breast cancer AND Member has a diagnosis of hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease AND Member has one or more documented PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test AND Member has progressed on at least one prior endocrine-based regimens [including one line containing a cyclin-dependent kinase (CDK) 4 & 6 inhibitor (e.g., ribociclib, abemaciclib)] and meets one of the following: Has been treated previously in the metastatic setting OR Has recurrence on or within 12 months of completing adjuvant therapy AND Member will be using Truqap (capivasertib) in combination with fulvestrant.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TRUSELTIQ - CAPSULE

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	
Part B Prerequisite	

## TUKYSA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on Tukysa (tucatinib)
<b>Required Medical Information</b>	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. Colorectal cancer. The member has a diagnosis of RAS wild-type HER2-positive unresectable or metastatic colorectal cancer AND The member has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy AND Tukysa will be given in combination with trastuzumab product.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## TURALIO - CAPSULE

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
Part B Prerequisite	

## TYMLOS - PEN INJECTOR (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The member has 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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## UBRELVY - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Acute Migraine: The member will be utilizing Ubrely (ubrogepant) for the acute treatment of migraines AND The member has had previous treatment, intolerance, or contraindication to ONE of the following: naratriptan, rizatriptan, sumatriptan.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## UDENYCA - SYRINGE (ML)

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 biosimilar 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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
Part B Prerequisite	

## UDENYCA AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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 biosimilar 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.
<b>Required Medical Information</b>	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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
<b>Part B Prerequisite</b>	

# UDENYCA ONBODY - SYRINGE, WITH WEARABLE INJECTOR

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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 biosimilar 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.
<b>Required Medical Information</b>	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 pegfilgrastim product 24-72 hours after the administration of myelosuppressive 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 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 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	Hematopoietic Subsyndrome of Acute Radiation Syndrome. The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation.
<b>Part B Prerequisite</b>	

## VALCHLOR - GEL (GRAM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	NA
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Valchlor (mechlorethamine).
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## vancomycin - CAPSULE

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
Part B Prerequisite	

## VANFLYTA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on or following Vanflyta (quizartinib).
<b>Required Medical Information</b>	Acute Myeloid Leukemia (newly diagnosed). The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 internal tandem duplication (ITD)-positive disease AND The member will be using Vanflyta (quizartinib) in combination with standard cytarabine and anthracycline induction and cytarabine consolidation chemotherapy OR The member will be using Vanflyta (quizartinib) as maintenance monotherapy following consolidation with systemic chemotherapy (excludes maintenance monotherapy following allogeneic hemopoietic stem cell transplantation).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VENCLEXTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	<p>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).</p> <p>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.</p> <p>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 Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine.</p> <p>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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

# VENCLEXTA - TABLET

Part B Prerequisite	
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## VENCLEXTA STARTING PACK - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	<p>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).</p> <p>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.</p> <p>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 Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine.</p> <p>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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

# VENCLEXTA STARTING PACK - TABLET, DOSE PACK

Part B Prerequisite	
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## VENTAVIS - AMPUL FOR NEBULIZATION (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 III-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. BvsD Coverage Determination may also be required.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VERQUVO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Heart Failure: The member must meet ALL of the following criteria: Diagnosis of symptomatic chronic heart failure (e.g. NYHA Class II-IV) AND Left ventricular ejection fraction less than or equal to 45% AND Worsening cardiac event resulting in hospitalization or use of IV diuretics within the past six months.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VERSACLOZ - SUSPENSION, ORAL (FINAL DOSE FORM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	NA
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	NA
<b>Part B Prerequisite</b>	

## VERZENIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	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., anastrozole) 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., anastrozole) 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 Verzenio (abemaciclib) is given in combination with tamoxifen or aromatase inhibitor.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	

## vigabatrin - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## vigadrone - POWDER IN PACKET (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## VIGAFYDE - SOLUTION, ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Infantile Spasms: The member has a documented diagnosis of infantile spasms.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## vigpoder - POWDER IN PACKET (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VIIBRYD - TABLET, DOSE PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Major depressive disorder: The member has 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) AND 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## vilazodone - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Major depressive disorder: The member has 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) AND 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VITRAKVI - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Solid Tumors. Member has been diagnosed with advanced or metastatic solid tumor OR Member is not a candidate for surgical resection AND Member has a documented neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known resistance mutation AND Member is not a candidate for or does not have alternative systemic therapy treatment options.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VIZIMPRO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
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	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	

## VONJO - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on Vonjo (pacritinib).
<b>Required Medical Information</b>	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 10 <sup>9</sup> /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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Initial Authorization: 6 months duration. Reauthorization: 6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VORANIGO - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members have experienced disease progression while on Voranigo (vorasidenib).
<b>Required Medical Information</b>	Gliomas: The member has a diagnosis of grade 2 astrocytoma or oligodendroglioma AND The member has a documented isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation AND The member is using Voranigo (vorasidenib) as single agent following surgery (i.e., biopsy, sub-total resection, or gross total resection).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## voriconazole - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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. Prophylaxis of both Candida and Aspergillus species in post-liver transplant. 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.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## VOSEVI - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. The member has relapsed after completing a full course of or has a contraindication to: Genotypes 1, 4, 5, and 6: Harvoni OR Epclusa. Genotypes 2 and 3: The member has relapsed after completing a full course of or has a contraindication to Epclusa.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VOTRIENT - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on previous pazopanib therapy.
<b>Required Medical Information</b>	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, Hurthle cell carcinoma, papillary 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## VRAYLAR - CAPSULE

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	<p>Schizophrenia: The member must be utilizing Vraylar for the treatment of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Vraylar for the treatment of bipolar I disorder (manic or mixed episode) 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 or lurasidone. Major Depressive Disorder: The member has 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) AND The member has had previous treatment, contraindication, or intolerance to at least one antidepressant of adequate dose (i.e. as determined by the treating provider based on individual patient characteristics) and duration (i.e. at least 8 weeks) used as monotherapy for MDD AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one generic oral atypical antipsychotic therapy that has been used as adjunctive (i.e. add-on) to antidepressant therapy AND Vraylar must be used as adjunctive treatment to antidepressant therapy and not as monotherapy.</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## VYNDAQEL - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	The member is being treated by a specialist (e.g. cardiologist).
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## WELIREG - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Member experiences disease progression on Welireg (belzutifan).
<b>Required Medical Information</b>	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). Renal Cell Carcinoma (RCC). The member has advanced renal cell carcinoma AND The member failed to achieve treatment goals or has documented intolerance when previously treated with both of the following: programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor AND a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) AND Welireg (belzutifan) is administered as monotherapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	VHL disease: Initial auth: 6 months duration. Reauth: plan year duration. RCC: Plan year duration.
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## XALKORI - PELLETS IN DISPENSING CAPSULE

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members using Xalkori (crizotinib) for adjuvant therapy.
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	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.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## XATMEP - SOLUTION, ORAL

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members with disease progression on Xatmep (methotrexate) (applies to acute lymphoblastic leukemia only).
<b>Required Medical Information</b>	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 of, or had an inadequate response to first-line therapy (e.g. non-steroidal anti-inflammatory agents (NSAIDs)) as determined by prescriber AND The member has had previous treatment or intolerance to generic methotrexate. BvsD Coverage Determination may also be required.
<b>Age Restriction</b>	The member is less than 18 years of age.
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## XDEMVIY - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Demodex blepharitis: Has a diagnosis of Demodex blepharitis AND Has collarettes present on more than 10 lashes on the upper eyelid upon slit lamp examination AND Has at least mild erythema of the upper eyelid margin AND Xdemvy (lotilaner) is prescribed by or in consultation with an optometrist or ophthalmologist.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	

## XGEVA - VIAL (ML)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Concurrent use of bisphosphonate therapy (e.g., zoledronic acid, pamidronate).
<b>Required Medical Information</b>	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.. Multiple Myeloma: The member has a diagnosis of multiple myeloma. 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## XIFAXAN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Traveler's diarrhea: Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli AND Member's condition is not complicated by fever or blood in the stool AND Member has tried or cannot use ciprofloxacin, levofloxacin, or azithromycin. Hepatic encephalopathy prophylaxis: Member has had at least one overt episode of hepatic encephalopathy (HE) AND Xifaxan (rifaximin) is being used to reduce the risk of HE recurrence. Irritable bowel syndrome with diarrhea (IBS-D): Member has a diagnosis of Irritable bowel syndrome with diarrhea (IBS-D).</p>
Age Restriction	<p>Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D.</p>
Prescriber Restriction	<p>Licensed Practitioner</p>
Coverage Duration	<p>Plan year duration</p>
Other Criteria	
Part B Prerequisite	

## XOLAIR - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>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 serum 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.</p>
Age Restriction	<p>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. The patient is 1 year or older for IgE Mediated Food Allergy.</p>
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	<p>Nasal Polyps: 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. IgE Mediated Food Allergy: Member has been diagnosed with IgE mediated food allergy AND Member is using Xolair to reduce allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one of more foods AND Member is using in conjunction with food allergen avoidance.</p>
Part B Prerequisite	

## XOSPATA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## XPOVIO - TABLET

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	
Part B Prerequisite	

# XTANDI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
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). Prostate Cancer (non-metastatic castration-sensitive): The member has a diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC) with biochemical recurrence at high risk for metastasis (biochemical recurrence at high risk for metastasis defined as prostate-specific antigen [PSA] doubling time less than or equal to 9 months, PSA greater than or equal to 1 ng/mL post radical prostatectomy, or screening PSA greater than or equal to 2 ng/mL above nadir post radiotherapy).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	nmCSPC: Plan year duration. All other indications: 6 months duration.
Other Criteria	
Part B Prerequisite	

## ZARXIO - SYRINGE (ML)

PA Criteria	Criteria Details
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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 biosimilar pegfilgrastim (e.g. pegfilgrastim-jmbd or pegfilgastrim-cbqv, within seven days of pegfilgrastim dose).
<b>Required Medical Information</b>	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 filgrastim product 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 filgrastim product 24-72 hours after the administration of myelosuppressive 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
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 Months Duration



## ZARXIO - SYRINGE (ML)

<b>Other Criteria</b>	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 filgrastim product 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 filgrastim product 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.
<b>Part B Prerequisite</b>	

## ZEJULA - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
<b>Required Medical Information</b>	Epithelial Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer subsequent 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 Zejula (niraparib) as a monotherapy*. *Discontinue Bevacizumab product before initiating maintenance therapy with Zejula. Advanced 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ZELBORAF - TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	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 Mekinist (trametinib)].
<b>Required Medical Information</b>	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 (cobimetinib). 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.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	6 months duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ZEMAIRA - VIAL (EA)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	IgA deficient members or presence of antibodies against IgA.
<b>Required Medical Information</b>	The member must meet ALL of the following criteria: Diagnosis of congenital alpha 1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed AND Has an alpha 1-antitrypsin phenotype of PiZZ, PiZ(null), or PI (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 57mg/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 alpha 1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.)
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ZOKINVY - CAPSULE

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
Part B Prerequisite	

## zoledronic acid-mannitol-water - IV SOLUTION, PIGGYBACK, BOTTLE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Osteoporosis: The member has a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to another 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 to another 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 to another 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 to another 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).</p>
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## ZOLINZA - CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cutaneous T-Cell Lymphoma (CTCL). The member has a diagnosis of progressive, persistent, or recurrent disease or The member will be using Zolinza (vorinostat) as primary treatment or adjuvant therapy.
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ZONISADE - SUSPENSION, ORAL (FINAL DOSE FORM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Partial-onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Zonisade (zonisamide) will be used in combination with at least one other for controlling partial-onset seizures AND Member has tried or cannot use zonisamide capsules AND at least one other drug for controlling partial-onset seizures (e.g levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan year duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	



## ZTALMY - SUSPENSION, ORAL (FINAL DOSE FORM)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restriction</b>	
<b>Prescriber Restriction</b>	Licensed Practitioner
<b>Coverage Duration</b>	Plan Year Duration
<b>Other Criteria</b>	
<b>Part B Prerequisite</b>	

## ZURZUVAE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	<p>Postpartum Depression. The member has a documented diagnosis of a major depressive episode as defined by DSM-5 criteria and severity as determined by an appropriate depression rating scale (e.g. HAM-D, MADRS, PHQ-9) with onset of symptoms in the third trimester of pregnancy or within 4 weeks of delivery AND For the current major depressive episode, the member has had prior treatment, contraindication, or intolerance to an antidepressant other than zuranolone or brexanolone OR Physician attests with documentation that the severity of the depression would place the health of the mother or infant at significant risk AND The member will be receiving Zurzuvae therapy no later than one year postpartum AND The member is not pregnant at initiation of Zurzuvae therapy AND The member will be receiving no more than one 14-day course of treatment with Zurzuvae for the current episode of postpartum depression.</p>
Age Restriction	The member is at least 18 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	30 day duration
Other Criteria	
Part B Prerequisite	

## ZYDELIG - TABLET

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).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	

## ZYKADIA - TABLET

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
Part B Prerequisite	

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

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### Products Affected

- Astagraf XL 0.5 MG; 1 MG; 5 MG; capsule,extended release
- azathioprine 100 MG; 50 MG; 75 MG; tablet
- CellCept 200 MG/ML; 250 MG; 500 MG; oral suspension
- CellCept Intravenous 500 MG; intravenous solution
- cyclophosphamide 25 MG; 50 MG; tablet
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; capsule
- Envarsus XR 0.75 MG; 1 MG; 4 MG; tablet,extended release
- Gengraf 100 MG; 100 MG/ML; 25 MG; capsule
- Imuran 50 MG; tablet
- Medrol 16 MG; 2 MG; 4 MG; 8 MG; tablet
- methylprednisolone 16 MG; 32 MG; 4 MG; 8 MG; tablet
- mycophenolate 500 MG; intravenous solution
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; oral powder for suspension
- mycophenolate sodium 180 MG; 360 MG; tablet,delayed release
- Myhibbin 200 MG/ML; oral suspension
- Neoral 100 MG; 100 MG/ML; 25 MG; oral solution
- Pediapred 5 mg base/5 mL (6.7 MG/5 ML); oral solution
- Azasan 100 MG; 75 MG; tablet
- CellCept 200 MG/ML; 250 MG; 500 MG; capsule
- CellCept 200 MG/ML; 250 MG; 500 MG; tablet
- cyclophosphamide 25 MG; 50 MG; capsule
- cyclosporine 100 MG; 25 MG; capsule
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; oral solution
- everolimus (immunosuppressive) 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet
- Gengraf 100 MG; 100 MG/ML; 25 MG; oral solution
- Jylamvo 2 MG/ML; oral solution
- methotrexate sodium 2.5 MG; tablet
- Millipred 5 MG; tablet
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; capsule
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; tablet
- Myfortic 180 MG; 360 MG; tablet,delayed release
- Neoral 100 MG; 100 MG/ML; 25 MG; capsule
- Orapred ODT 10 MG; 15 MG; 30 MG; disintegrating tablet
- prednisolone 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); disintegrating tablet

- prednisolone 15 MG/5 ML; 5 MG; oral solution
- prednisolone sodium phosphate 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); oral soln
- 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; 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
- tacrolimus 0.5 MG; 1 MG; 5 MG; capsule, immediate-release
- Trexall 10 MG; 15 MG; 5 MG; 7.5 MG; tablet
- Xatmep 2.5 MG/ML; oral solution
- prednisolone 15 MG/5 ML; 5 MG; tablet
- prednisolone sodium phosphate 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); oral solution
- prednisone 1 MG; 10 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; tablet
- 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 XL 0.5 MG; 1 MG; 5 MG; capsule, extended release 24 hr
- Veripred 20 20 mg/5 mL (4 MG/ML); oral solution
- Zortress 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet

## Important

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If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

### Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

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## Multi-Language Insert

### Multi-language Interpreter Services

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**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.



**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。