

## **ABIRATERONE**

---

### **Products Affected**

- *abiraterone acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Castration-resistant metastatic prostate cancer and used in combination with prednisone, or B.) High risk, castration-sensitive metastatic prostate cancer and used in combination with prednisone
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ACITRETIN

---

## Products Affected

- *acitretin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Severely impaired liver or kidney function, B.) Chronic abnormally elevated blood lipid values, C.) Concomitant use of methotrexate or tetracyclines, D.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of severe, recalcitrant psoriasis (including plaque, guttate, erythrodermic palmar- plantar and pustular) AND patient must have tried and failed, contraindication or intolerance to one formulary first line agent (e.g., Topical Corticosteroids (betamethasone, fluocinonide, desoximetasone), Topical Calcipotriene/Calcitriol, Topical Calcipotriene, OR Topical Tazarotene)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ACTIMMUNE

---

## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic granulomatous disease for use in reducing the frequency and severity of serious infections, or B.) Severe, malignant osteopetrosis (SMO)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ADEMPAS

---

## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form, B.) Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline), C.) Pregnancy, or D.) Patients with pulmonary hypertension associated with idiopathic interstitial pneumonia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.), or B.) Chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable (Female patients must be enrolled in the ADEMPAS REMS program)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **ALECENSA**

---

### **Products Affected**

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic anaplastic lymphoma kinase (ALK) positive non-small cell lung cancer as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ALPHA-1 PROTEINASE INHIBITOR

---

## Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Immunoglobulin A (IgA) deficiency with antibodies against IgA
<b>Required Medical Information</b>	Diagnosis of alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency in adult patients with emphysema
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ALUNBRIG

---

## Products Affected

- ALUNBRIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of anaplastic lymphoma kinase-positive (ALK) metastatic non-small cell lung cancer (NSCLC)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AMBRISENTAN

---

## Products Affected

- *ambrisentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Pregnancy, or B.) Idiopathic pulmonary fibrosis (IPF), including those with pulmonary hypertension
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension classified as WHO Group I, confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# APOMORPHINE

---

## Products Affected

- *apomorphine hcl subcutaneous*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with 5-HT(3) receptor antagonists (e.g. ondansetron, granisetron, dolasetron, palonosetron, alosetron, etc.)
<b>Required Medical Information</b>	Diagnosis of Parkinson's disease (PD) and patient is experiencing acute intermittent hypomobility (defined as off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ARCALYST

---

## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS), B.) Deficiency of interleukin-1 receptor antagonist (DIRA) and patient requires maintenance therapy for remission, or C.) Recurrent pericarditis (RP) and reduction in risk of recurrence
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **ARIKAYCE**

---

### **Products Affected**

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Known sensitivity to any aminoglycoside
<b>Required Medical Information</b>	Diagnosis of pulmonary Mycobacterium avium complex (MAC) infection and used as part of a combination antibacterial regimen in treatment refractory patients (greater than 6 months of a multidrug background regimen)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AURYXIA

---

## Products Affected

- AURYXIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Iron overload syndrome (e.g. hemochromatosis)
<b>Required Medical Information</b>	Diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD) on dialysis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or nephrologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Ferric Citrate is NOT approvable for iron deficiency anemia per Part D law
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AUSTEDO

---

## Products Affected

- AUSTEDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Suicidal ideation and/or untreated or inadequately treated depression, B.) Hepatic impairment, C.) Taking MAOIs, reserpine, or tetrabenazine
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chorea associated with Huntington's disease (Huntington's chorea), or B.) Tardive dyskinesia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or psychiatrist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AYVAKIT

---

## Products Affected

- AYVAKIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Unresectable or metastatic gastrointestinal stromal tumor, with a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations, or B.) Advanced systemic mastocytosis (AdvSM), including patients with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, or mast cell leukemia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **BALVERSA**

---

### **Products Affected**

- BALVERSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 or FGFR2 genetic alterations and patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# BENLYSTA

---

## Products Affected

- BENLYSTA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Active, autoantibody-positive, system lupus erythematosus (SLE), or B.) Active lupus nephritis and patient is receiving standard therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or rheumatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **BESREMI**

---

### **Products Affected**

- BESREMI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Existence of, or history of severe psychiatric disorders (severe depression, suicidal ideation, or suicide attempt), B.) Hypersensitivity to interferons including interferon alfa-2b or excipients, C.) Hepatic impairment (Child-Pugh B or C), D.) History or presence of active serious or untreated autoimmune disease, or E.) Immunosuppressed transplant recipients
<b>Required Medical Information</b>	Diagnosis of polycythemia vera
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# BEXAROTENE GEL

---

## Products Affected

- *bexarotene*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of primary cutaneous T-cell lymphoma (CTCL Stage 1A/1B) and patient had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) indicated for cutaneous manifestations of CTCL
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **BEXAROTENE ORAL**

---

### **Products Affected**

- *bexarotene*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of cutaneous T-cell lymphoma (CTCL) and patient is not a candidate for or had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) for cutaneous manifestations of CTCL
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# BOSENTAN

---

## Products Affected

- *bosentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant cyclosporine A or glyburide therapy, or B.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension (WHO Group I) and patient has New York Heart Association (NYHA) Functional Class II-IV, confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# **BOSULIF**

---

## **Products Affected**

- BOSULIF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or inadequate response to prior therapy, or B.) Newly diagnosed chronic phase Philadelphia chromosome-positive (Ph+) CML
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# BRAFTOVI

---

## Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) unresectable or metastatic melanoma with documented BRAF V600E or V600K mutation as detected by a FDA-approved test and used in combination with binimetinib, or B.) metastatic colorectal cancer with documented BRAF V600E mutation as detected by a FDA-approved test, patient has received prior therapy, and braftovi used in combination with cetuximab.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **BRUKINSA**

---

### **Products Affected**

- BRUKINSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following: A.) mantle cell lymphoma (MCL) and patient has received at least one prior therapy or B.) Treatment of adult patients with Waldenström macroglobulinemia or C.) Treatment of adult patients with relapsed or refractory marginal zone lymphoma who have received at least one anti-CD20-based regimen
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# BYLVAY

---

## Products Affected

- BYLVAY
- BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of progressive familial intrahepatic cholestasis-associated pruritus
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# CABLIVI

---

## Products Affected

- CABLIVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) and used in combination with plasma exchange and immunosuppression therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CABOMETYX

---

## Products Affected

- CABOMETYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma, B.) Advanced hepatocellular carcinoma (HCC) and patient has been previously treated with sorafenib, C.) Advanced renal cell carcinoma and used as first line treatment in combination with nivolumab or D.) Treatment of adults and pediatric patients 12 years and older with locally advanced or metastatic differentiated thyroid cancer that has progressed following VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CALQUENCE

---

## Products Affected

- CALQUENCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Mantle cell lymphoma (MCL) and patient has received at least 1 prior therapy, B.) Chronic lymphocytic leukemia (CLL), or C.) Small lymphocytic lymphoma (SLL)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CAMZYOS

---

## Products Affected

- CAMZYOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) in adult patients
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **CAPRELSA**

---

### **Products Affected**

- CAPRELSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Congenital long QT syndrome
<b>Required Medical Information</b>	Diagnosis of metastatic or unresectable locally advanced medullary thyroid cancer (MTC) AND disease is symptomatic or progressive
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CARGLUMIC ACID

---

## Products Affected

- *carglumic acid oral tablet soluble*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) N-acetyl glutamate synthase (NAGS) deficiency with acute or chronic hyperammonemia, or B.) Propionic or methylmalonic acidemia with acute hyperammonemia
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CAYSTON

---

## Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (confirmed by appropriate diagnostic or genetic testing) and patient has suspected or confirmed <i>Pseudomonas aeruginosa</i> lung infection
<b>Age Restrictions</b>	7 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CHANTIX

---

## Products Affected

- *varenicline tartrate oral tablet*
- *varenicline tartrate oral tablet therapy pack*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of nicotine addiction and documentation of trial of previous smoking cessation therapies (nicotine replacement therapy or a therapeutic course of bupropion (7-9 weeks)). Otherwise, varenicline will require a prior authorization exception request indicating: (1) history of inadequate treatment response with a nicotine or bupropion smoking cessation therapy, OR (2) history of adverse event with a nicotine or bupropion smoking cessation therapy, OR (3) smoking cessation therapy with nicotine or bupropion is contraindicated.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **CNS STIMULANTS**

---

### **Products Affected**

- *armodafinil*
- *modafinil*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Obstructive sleep apnea (OSA) confirmed by sleep lab evaluation, B.) Narcolepsy confirmed by sleep lab evaluation, or C.) Shift work disorder (SWD)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# COMETRIQ

---

## Products Affected

- COMETRIQ (100 MG DAILY DOSE)  
ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE)  
ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of progressive, metastatic medullary thyroid cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **COPIKTRA**

---

### **Products Affected**

- COPIKTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsed or refractory chronic lymphocytic leukemia, or B.) Small lymphocytic lymphoma
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CORLANOR

---

## Products Affected

- CORLANOR ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Decompensated acute heart failure, B.) hypotension (i.e. blood pressure less than 90/50 mmHg), C.) sick sinus syndrome or sinoatrial block or 3rd degree AV block (unless a functioning demand pacemaker is present), D.) bradycardia (i.e., resting heart rate less than 60 bpm prior to treatment), E.) Severe hepatic impairment (Child-Pugh C), F.) Pacemaker dependent (heart rate maintained exclusively by the pacemaker), G.) Concomitant use of strong CYP3A4 inhibitors
<b>Required Medical Information</b>	Diagnosis of one of the following A.) stable, symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate 70 beats per minute or more and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use, or B.) stable, symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an elevated heart rate
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# COSENTYX

---

## Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Ankylosing spondylitis and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Humira, Enbrel), B.) Moderate to severe plaque psoriasis in adults and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Humira, Enbrel, Skyrizi, Stelara), C.) Moderate to severe plaque psoriasis in patients 6 years to less than 18 years of age and patient has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Enbrel, Stelara), D.) Active psoriatic arthritis in adult patient and has trial and failure, contraindication, or intolerance to two preferred products, (i.e. Humira, Enbrel, Stelara), E.) Active psoriatic arthritis in patients 2 years to less than 18 years of age, F.) Non-radiographic axial spondyloarthritis or G.) Active enthesitis-related arthritis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Screening for latent tuberculosis infection is required prior to initiation of treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# COTELLIC

---

## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable or metastatic malignant melanoma with BRAF V600E OR V600K mutation, and documentation of combination therapy with vemurafenib (Zelboraf)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CYSTAGON

---

## Products Affected

- CYSTAGON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Known serious hypersensitivity to penicillamine or cysteamine
<b>Required Medical Information</b>	Diagnosis of nephropathic cystinosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CYSTEAMINE OPHTH

---

## Products Affected

- CYSTADROPS
- CYSTARAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystinosis and patient has corneal cystine crystal accumulation
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## DALFAMPRIDINE

---

### Products Affected

- *dalfampridine er*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) History of seizure. B.) Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute)
<b>Required Medical Information</b>	Diagnosis of multiple sclerosis and patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DAURISMO

---

## Products Affected

- DAURISMO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of newly diagnosed acute myeloid leukemia (AML) and used in combination with cytarabine in patients 75 years of age or older OR in patients that have comorbidities that preclude use of intensive induction chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DEFERASIROX

## Products Affected

- *deferasirox oral tablet*
- *deferasirox oral tablet soluble*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Creatinine clearance less than 40 mL/min, B.) Poor performance status, C.) Platelet count less than 50 x 10 <sup>9</sup> /L, D.) Advanced malignancy, E.) High-risk myelodysplastic syndrome (MDS)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic iron overload in patients with non-transfusion-dependent thalassemia syndromes who have liver iron concentrations of at least 5 mg Fe/g dry weight AND serum ferritin level greater than 300 mcg/L, or B.) Chronic iron overload due to blood transfusions (transfusion hemosiderosis) as evidenced by transfusion of at least 100 mL/kg packed red blood cells AND serum ferritin level greater than 1000 mcg/L
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DEFERIPRONE

---

## Products Affected

- *deferiprone*
- FERRIPROX ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Must meet all of the following 1.) Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease, or other anemias, 2.) Patient has failed prior chelation therapy, and 3.) Patient has an absolute neutrophil count greater than $1.5 \times 10^9/L$
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DIACOMIT

---

## Products Affected

- DIACOMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of severe myoclonic epilepsy in infancy (Dravet syndrome) in patients taking clobazam
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DICLOFENAC TOPICAL

---

## Products Affected

- *diclofenac sodium external gel 3 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Actinic keratosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## DIMETHYL FUMARATE

---

### Products Affected

- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DOJOLVI

---

## Products Affected

- DOJOLVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Long-chain fatty acid oxidation disorder (LC-FAOD)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **DRONABINOL**

---

### **Products Affected**

- *dronabinol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Sesame oil hypersensitivity
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Anorexia associated to AIDS, or B.) Chemotherapy-induced nausea and vomiting
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# DROXIDOPA

---

## Products Affected

- *droxidopa*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) caused by primary autonomic failure (e.g., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **DUPIXENT**

---

### **Products Affected**

- DUPIXENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe atopic dermatitis and patient has trial/failure, contraindication, or intolerance to two of the following 1.) Topical corticosteroid, and/or 2.) Topical calcineurin inhibitor, B.) Eosinophilic phenotype or oral corticosteroid- dependent moderate to severe asthma and used as an adjunct treatment, C.) Chronic rhinosinusitis with nasal polyposis and used as an adjunct treatment, D.) Eosinophilic esophagitis, or E.) Prurigo nodularis
<b>Age Restrictions</b>	6 months of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# EMGALITY

---

## Products Affected

- EMGALITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic or episodic migraine disorder and patient has documented trial, inadequate response, or contraindication to at least 2 generic formulary drugs used for migraine prevention (i.e., propranolol, topiramate, divalproex, timolol), or B.) Episodic cluster headache
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ENBREL

## Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, or E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Screening for latent tuberculosis infection is required prior to initiation of treatment
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

# ENDARI

---

## Products Affected

- ENDARI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of sickle cell disease AND one of the following 1.) Patient has acute complications and is being treated with Hydroxyurea, or 2.) Patient has acute complications and is unable to tolerate Hydroxyurea
<b>Age Restrictions</b>	5 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ENSPRYNG

---

## Products Affected

- ENSPRYNG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Active Hepatitis B infection, or B.) Active or untreated latent tuberculosis
<b>Required Medical Information</b>	Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) in patients who are anti-aquaporin-4 (AQP4) antibody positive
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, immunologist, or ophthalmologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# EPIDIOLEX

---

## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Lennox-Gastaut syndrome, B.) Severe myoclonic epilepsy in infancy (Dravet syndrome), or C.) Seizures associated with tuberous sclerosis complex
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## EPOETIN THERAPY

---

### Products Affected

- RETACRIT INJECTION SOLUTION                      UNIT/ML, 4000 UNIT/ML, 40000  
10000 UNIT/ML, 10000 UNIT/ML(1ML),              UNIT/ML  
2000 UNIT/ML, 20000 UNIT/ML, 3000

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Non-myeloid neoplastic disease and utilized for the treatment of chemotherapy induced anemia, B.) HIV infection and utilized for the treatment of zidovudine induced anemia, C.) Chronic kidney disease resulting in anemia, or D.) High risk surgical candidate status at risk for perioperative blood loss and undergoing elective, noncardiac, or nonvascular surgery
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ERIVEDGE

---

## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic basal cell carcinoma, or B.) Locally advanced basal cell carcinoma that has recurred following surgery or the patient is not a candidate for surgery or radiation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **ERLEADA**

---

### **Products Affected**

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Nonmetastatic, castration-resistant prostate cancer, or B.) Metastatic, castration-sensitive prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ERLOTINIB

---

## Products Affected

- *erlotinib hcl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally advanced, unresectable, or metastatic pancreatic cancer and erlotinib will be used in combination with gemcitabine, B.) Locally advanced or metastatic non-small cell lung cancer with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility AND one of the following 1.) Erlotinib will be used as first-line treatment, 2.) Failure with at least one prior chemotherapy regimen, or 3.) No evidence of disease progression after four cycles of first-line platinum-based chemotherapy and erlotinib will be used as maintenance treatment
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **ESBRIET**

---

### **Products Affected**

- ESBRIET ORAL CAPSULE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of idiopathic pulmonary fibrosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# EVEROLIMUS

---

## Products Affected

- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Hypersensitivity to everolimus or excipients, or B.) Hypersensitivity to rapamycin derivatives (e.g. sirolimus)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Renal angiomyolipoma and tuberous sclerosis complex (TSC) not requiring immediate surgery, B.) Advanced hormone receptor-positive, HER2 negative breast cancer in postmenopausal women and taken in combination with exemestane, after failure with letrozole or anastrozole, C.) Progressive, well-differentiated, nonfunctional neuroendocrine tumors of gastrointestinal or lung origin and disease is unresectable, locally advanced, or metastatic, D.) Pancreatic progressive neuroendocrine tumors and disease is unresectable, locally advanced, or metastatic, E.) Advanced renal cell carcinoma (RCC) after failure with sunitinib or sorafenib, F.) Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex in patients who are not candidates for curative surgical resection
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **EVEROLIMUS SUSPENSION**

---

### **Products Affected**

- *everolimus oral tablet soluble*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Hypersensitivity to everolimus or excipients, or B.) Hypersensitivity to rapamycin derivatives (e.g. sirolimus)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Tuberous sclerosis complex (TSC)-associated partial-onset seizures, or B.) Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex in patients who are not candidates for curative surgical resection
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# EVRYSDI

---

## Products Affected

- EVRYSDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of spinal muscular atrophy (SMA)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **EXKIVITY**

---

### **Products Affected**

- EXKIVITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with EGFR exon 20 insertion mutations (as confirmed by an FDA-approved test) AND whose disease has progressed on or after platinum-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# FEBUXOSTAT

---

## Products Affected

- *febuxostat*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of azathioprine or mercaptopurine
<b>Required Medical Information</b>	Diagnosis of Gout and all of the following 1.) documented inadequate treatment response, adverse event, or contraindication to maximally titrated dose of Allopurinol, and 2.) patients with established cardiovascular disease, prescriber attests that benefit of treatment outweighs the risk of treatment
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## FENTANYL ORAL

---

### Products Affected

- *fentanyl citrate buccal lozenge on a handle*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Use in opioid non-tolerant patients, C.) Known or suspected gastrointestinal obstruction, including paralytic ileus, D.) Acute or severe bronchial asthma and used in an unmonitored setting (absence of resuscitative equipment)
<b>Required Medical Information</b>	Must meet all of the following 1.) Diagnosis of cancer-related breakthrough pain, 2.) Patient is currently receiving/tolerant to around-the-clock opioid therapy for persistent cancer pain, and 3.) Patient and prescriber are enrolled in the TIRF REMS Access Program
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# FENTANYL PATCH

---

## Products Affected

- *fentanyl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Mild or intermittent pain management, C.) Use in opioid non-tolerant patients, D.) Known or suspected gastrointestinal obstruction, including paralytic ileus, E.) Acute or severe bronchial asthma and used in an unmonitored setting (absence of resuscitative equipment)
<b>Required Medical Information</b>	Must meet all of the following 1.) Patient is opioid tolerant (taking for one week or longer at least 60mg of morphine or equivalent daily) and 2.) Patient has tried at least one extended release oral opioids or is unable to take extended release oral opioids secondary to allergy, adverse events, swallowing difficulty, or uncontrollable nausea/vomiting
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **FINTEPLA**

---

### **Products Affected**

- FINTEPLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use of an MAOI, or B.) Use within 14 days of discontinuing an MAOI
<b>Required Medical Information</b>	Diagnosis of Severe myoclonic epilepsy in infancy (Dravet syndrome) or seizures associated with Lennox-Gastaut syndrome
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# FOTIVDA

---

## Products Affected

- FOTIVDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory advanced renal cell cancer (RCC) following 2 or more prior systemic therapies
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# **GALAFOLD**

---

## **Products Affected**

- GALAFOLD

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) mutation
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# GATTEX

---

## Products Affected

- GATTEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of short bowel syndrome and patient is dependent on parenteral support
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# GAVRETO

---

## Products Affected

- GAVRETO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic RET fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test, B.) Advanced or metastatic RET-mutant medullary thyroid cancer and patient requires systemic therapy, or C.) Advanced or metastatic RET fusion-positive thyroid and patient requires systemic therapy and is radioactive iodine-refractory, when radioactive iodine is appropriate
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# GILENYA

## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure, B.) History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker, C.) Baseline QTC interval greater than or equal to 500 milliseconds, D.) Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	10 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# GILOTRIF

---

## Products Affected

- GILOTRIF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have nonresistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test, or B.) Metastatic squamous NSCLC with progression after platinum-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# GLATIRAMER

---

## Products Affected

- *glatiramer acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# GROWTH HORMONE

## Products Affected

- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Use for growth promotion in pediatric patients with closed epiphyses, B.) Acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure, C.) Active malignancy, D.) Active proliferative or severe nonproliferative diabetic retinopathy, E.) Prader-Willi Syndrome in patients who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment
<b>Required Medical Information</b>	Diagnosis of pediatric indication: A.) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B.) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C.) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D.) SHOX deficiency or Noonan syndrome E.) PWS confirmed by genetic testing, F.) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A.) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone [preferred], glucagon, arginine), B.) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C.) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D.) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than

<b>PA Criteria</b>	<b>Criteria Details</b>
	2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an Endocrinologist or Nephrologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **GUANFACINE ER**

---

### **Products Affected**

- *guanfacine hcl er*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of attention deficit hyperactivity disorder (ADHD)
<b>Age Restrictions</b>	6 years of age to 17 years of age
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HEPATITIS B

---

## Products Affected

- *adefovir dipivoxil*
- BARACLUDE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of chronic hepatitis B and all of the following 1.) Patient has or had evidence of viral replication prior to initiation, 2.) Patient has evidence of persistent elevations in serum aminotransferase (ALT or AST) or histologically active disease, and 3.) Patient is receiving anti-retroviral therapy if the patient has HIV co-infection
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## HEPATITIS C

---

### Products Affected

- MAVYRET
- *sofosbuvir-velpatasvir*
- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. All genotypes will require trial/failure, contraindication to, or intolerance to Mavyret or Sofosbuvir-Velpatasvir prior to the approval of Vosevi.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	Duration of approval per AASLD Guidelines
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HETLIOZ

---

## Products Affected

- HETLIOZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Non-24-hour-sleep-wake disorder (Non-24), or B.) Nighttime sleep disturbances associated with Smith-Magenis Syndrome (SMS)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HUMIRA

## Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PEDIATRIC UC START
- HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA PEN-PSOR/UEVEIT STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy and when other systemic therapies are medically less appropriate, F.) Moderate to severe Crohn's disease in patients who have had an inadequate response to conventional therapy, G.) Moderate to severe ulcerative colitis in patients who have had an inadequate response to immunosuppressants (e.g. corticosteroids, azathioprine), H.) Non-infectious uveitis (including intermediate, posterior, and panuveitis), or I.) Moderate to severe hidradenitis suppurativa
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Screening for latent tuberculosis infection is required prior to initiation of treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HYFTOR

---

## Products Affected

- HYFTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Facial angiofibroma associated with tuberous sclerosis
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **IBRANCE**

---

### **Products Affected**

- IBRANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer used in combination with fulvestrant and disease has progressed following endocrine therapy, or B.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer used in combination with an aromatase inhibitor in postmenopausal women or men
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ICATIBANT

---

## Products Affected

- FIRAZYR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following and used as treatment for acute attacks A.) Hereditary angioedema (HAE) with C1 inhibitor deficiency (Type 1) confirmed by laboratory testing, or B.) HAE with C1 inhibitor dysfunction (Type 2) confirmed by laboratory testing, or C.) HAE with normal C1 inhibitor (Type 3) confirmed by laboratory testing and one of the following 1.) Positive test for an F12, angiotensin-1, or plasminogen gene mutation, or 2.) Family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, hematologist, or immunologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ICLUSIG

---

## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated, B.) Chronic phase, chronic myeloid leukemia (CML) in adult patients with resistance or intolerance to at least two prior kinase inhibitors, or C.) Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# IDHIFA

---

## Products Affected

- IDHIFA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase 2 (IDH2) mutation as detected by an FDA approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# IMATINIB

---

## Products Affected

- *imatinib mesylate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B.) Ph+ acute lymphoblastic leukemia (ALL), C.) Gastrointestinal stromal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D.) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E.) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F.) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, or G.) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# IMBRUVICA

---

## Products Affected

- IMBRUVICA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Mantle cell lymphoma (MCL) and patient has received at least one prior therapy, B.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL), C.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion, D.) Waldenstrom's macroglobulinemia (WM), E.) Marginal zone lymphoma (MZL) and patient requires systemic therapy and has received at least one prior anti-CD20-based therapy, or F.) Chronic graft vs host disease (cGVHD) after failure of a least one first-line corticosteroid therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# INCRELEX

---

## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Active or suspected malignancy, B.) Use for growth promotion in patients with closed epiphyses, or C.) Intravenous administration
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Severe primary insulin-like growth factor-1 (IGF-1) deficiency and utilized for pediatric treatment of growth failure, or B.) Growth hormone (GH) gene deletion and patient has developed neutralizing antibodies to GH and utilized for pediatric treatment of growth failure
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# INLYTA

---

## Products Affected

- INLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma and patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens), or B.) Advanced renal cell carcinoma and used as first-line therapy in combination with avelumab or pembrolizumab
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# INQOVI

---

## Products Affected

- INQOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# INREBIC

---

## Products Affected

- INREBIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **INTRAROSA**

---

### **Products Affected**

- INTRAROSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, or B.) Known or suspected estrogen-dependent neoplasia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) moderate to severe dyspareunia due to menopause, or B.) atrophic vaginitis due to menopause
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 3 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# IRESSA

---

## Products Affected

- IRESSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer (NSCLC) and must meet all of the following 1.) Tumor has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility and 2.) Used as first-line treatment
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **ISTURISA**

---

### **Products Affected**

- ISTURISA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Cushing's disease in patients for whom pituitary surgery is not an option or has not been curative
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ITRACONAZOLE

---

## Products Affected

- *itraconazole oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF), B.) Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.), C.) Concurrent use of CYP2D6 inhibitors (e.g., bupropion, fluoxetine, paroxetine, quinidine, terbinafine), D.) Renal or hepatic impairment and concomitant use of colchicine, fesoterodine, solifenacin, or telithromycin, E.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), or B.) Onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## ITRACONAZOLE SOLN

---

### Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF), B.) Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.), C.) Concurrent use of CYP2D6 inhibitors (e.g., bupropion, fluoxetine, paroxetine, quinidine, terbinafine), D.) Renal or hepatic impairment and concomitant use of colchicine, fesoterodine, solifenacin, or telithromycin, E.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# IVERMECTIN

---

## Products Affected

- *ivermectin oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Prevention or treatment of COVID-19
<b>Required Medical Information</b>	Diagnosis of one of the following: A.) Strongyloidiasis of the intestinal tract or B.) Onchocerciasis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# JAKAFI

---

## Products Affected

- JAKAFI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis, B.) Polycythemia vera AND patient has had an inadequate response to or is intolerant of hydroxyurea, C.) Acute graft versus host disease AND disease is refractory to steroid therapy, OR D.) Chronic graft versus host disease after failure of 1 or 2 lines of systemic therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KALYDECO

---

## Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (CF) and the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **KESIMPTA**

---

### **Products Affected**

- KESIMPTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Active Hepatitis B infection
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KISQALI

---

## Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hormone receptor (HR)-positive, HER-2 negative advanced or metastatic breast cancer in pre/perimenopausal or postmenopausal women and used in combination with an aromatase inhibitor, or B.) Hormone receptor (HR)-positive, HER-2 negative advanced or metastatic breast cancer in postmenopausal women and used in combination with fulvestrant
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **KISQALI FEMARA**

---

### **Products Affected**

- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hormone receptor (HR)-positive, HER-2 negative advanced or metastatic breast cancer in pre/perimenopausal or postmenopausal women
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KORLYM

---

## Products Affected

- KORLYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) pregnancy, B.) coadministration with simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges, C.) concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses, D.) history of unexplained vaginal bleeding, E.) endometrial hyperplasia with atypia or endometrial carcinoma
<b>Required Medical Information</b>	Diagnosis of endogenous Cushing syndrome in patients with type 2 diabetes mellitus or glucose intolerance and must meet all of the following 1.) Used to control hyperglycemia secondary to hypercortisolism, and 2.) Patient has failed or is not a candidate for surgery
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# KOSELUGO

---

## Products Affected

- KOSELUGO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of neurofibromatosis type 1 (NF1) in a patient who has symptomatic, inoperable plexiform neurofibromas (PN)
<b>Age Restrictions</b>	2 years of age to 17 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LAPATINIB

---

## Products Affected

- *lapatinib ditosylate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced or metastatic breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND meets one of the following A.) Used in combination with capecitabine in a patient who has received prior therapy including an anthracycline, a taxane, and trastuzumab, OR B.) Used in combination with letrozole in a postmenopausal female for whom hormonal therapy is indicated
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LENALIDOMIDE

---

## Products Affected

- *lenalidomide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Multiple myeloma and medication will be used in combination with dexamethasone, B.) Autologous hematopoietic stem-cell transplantation (HSCT) in multiple myeloma patients, C.) Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality or without additional cytogenetic abnormalities, D.) Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib, E.) Follicular lymphoma and used in combination with rituximab, or F.) Marginal zone lymphoma and used in combination with rituximab
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LENVIMA

---

## Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer, B.) Advanced renal cell carcinoma, in combination with everolimus, following one prior anti-angiogenic therapy, C.) Unresectable hepatocellular carcinoma, first-line therapy, D.) Advanced endometrial carcinoma that is not microsatellite instability-high or mismatch repair deficient, in combination with pembrolizumab, when disease has progressed following prior systemic therapy AND patient is not a candidate for curative surgery or radiation, or E.) Advanced renal cell carcinoma, in combination with pembrolizumab
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LEUKINE

---

## Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed, B.) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, C.) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT, D.) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy, E.) Hematopoietic subsyndrome of acute radiation syndrome (H-ARS) or F.) Autologous peripheral blood stem cell transplant, Following myeloablative chemotherapy.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LEUPROLIDE

---

## Products Affected

- ELIGARD
- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced or metastatic prostate cancer and patient has failed or is intolerant to Eligard (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), B.) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only), C.) Anemia due to uterine leiomyomata (Fibroids) (3.75 mg 1-month & 11.25 mg 3-month depots only) and patient is preoperative, or D.) Central precocious puberty (idiopathic or neurogenic) in children
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **LIDOCAINE PATCH**

---

### **Products Affected**

- *lidocaine external patch 5 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Pain associated with diabetic neuropathy, B.) Pain associated with cancer-related neuropathy, C.) Post-herpetic neuralgia, D.) Chronic back pain, or E.) Osteoarthritis of the knee or hip
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LINEZOLID

---

## Products Affected

- *linezolid intravenous solution 600 mg/300ml*
- *linezolid oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of MAOI therapy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Community acquired pneumonia, B.) Hospital-acquired pneumonia, C.) Vancomycin-resistant Enterococcus faecium infection, D.) Complicated skin and skin structure infections, or E.) Uncomplicated skin and skin structure infections
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **LIVMARLI**

---

### **Products Affected**

- LIVMARLI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cholestatic pruritus in patients with Alagille syndrome (ALGS)
<b>Age Restrictions</b>	1 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LIVTENCITY

---

## Products Affected

- LIVTENCITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of post-transplant cytomegalovirus (CMV) infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LONSURF

---

## Products Affected

- LONSURF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic colorectal cancer, previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy, or B.) Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan and if appropriate, HER2/neu-targeted therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LORBRENA

---

## Products Affected

- LORBRENA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A4 inducers
<b>Required Medical Information</b>	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LUMAKRAS

---

## Products Affected

- LUMAKRAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as determined by an FDA-approved test and patient has received at least one prior systemic therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# LUPKYNIS

---

## Products Affected

- LUPKYNIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)
<b>Required Medical Information</b>	Initial: Diagnosis of systemic lupus erythematosus (SLE) with active lupus nephritis (LN) Classes III, IV, V (alone or in combination), and all of the following: 1.) Baseline renal function of 45 mL/min/1.73 m <sup>2</sup> or greater, 2.) Will be used in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate, oral steroids, etc). Renewal: Improvement in urine protein to creatinine ratio (UPCR) (i.e. less than or equal to 0.5 mg/mg) AND estimated glomerular filtration rate (eGFR) of 60 mL/min/1.73 m <sup>2</sup> or greater, or no confirmed decrease from baseline in eGFR of greater than 20%
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist or nephrologist
<b>Coverage Duration</b>	Initial: 12 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# LYNPARZA

## Products Affected

- LYNPARZA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) HER2-negative, deleterious or suspected deleterious germline BRCA mutated metastatic breast cancer and patient has been previously treated with chemotherapy in neoadjuvant, adjuvant, or metastatic setting, B.) Advanced ovarian cancer with known or suspected BRCA mutation as detected by an FDA-approved test AND patient has trial and failure, contraindication, or intolerance to 3 or more prior lines of chemotherapy, C.) Recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer and used for maintenance treatment in patients who are in complete or partial response to platinum-based chemotherapy (e.g. cisplatin, carboplatin), D.) Deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with complete or partial response to first-line platinum-based chemotherapy, E.) Deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma and disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen, F.) Advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in complete or partial response to first-line platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA-mutation and/or genomic instability AND are using in combination with bevacizumab for maintenance treatment, or G.) Deleterious or suspected deleterious germline or somatic homologous recombination repair gene mutated metastatic castration-resistant prostate cancer in patients who have progressed following prior treatment with enzalutamide or abiraterone
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **MATULANE**

---

### **Products Affected**

- MATULANE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Inadequate marrow reserve
<b>Required Medical Information</b>	Diagnosis of Hodgkin's Disease, Stages III and IV and used in combination with other anticancer drugs
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# MAYZENT

---

## Products Affected

- MAYZENT
- MAYZENT STARTER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) CYP2C9*3/*3 genotype, B.) In the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III-IV heart failure, or C.) Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker
<b>Required Medical Information</b>	Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease and the following A.) Patients with relapsing forms of multiple sclerosis have history of/or contraindication to Avonex, Betaseron, Glatiramer, Gilenya, or Dimethyl Fumarate
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# MEKINIST

---

## Products Affected

- MEKINIST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and used in combination with dabrafenib and no locoregional treatment options, B.) Malignant melanoma with lymph node involvement and following complete resection with BRAF V600E or V600K mutations and used in combination with dabrafenib, C.) Unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutations and used in combination with dabrafenib or as monotherapy, D.) Metastatic non-small cell lung cancer, with BRAF V600E mutation, in combination with dabrafenib, or E.) Unresectable or metastatic solid tumors with BRAF V600E mutation, in combination with dabrafenib, and have progressed following prior treatment and have no satisfactory alternative treatment options
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# MEKTOVI

---

## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable or metastatic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA approved test AND used in combination with encorafenib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# METHOXSALLEN

---

## Products Affected

- *methoxsalen rapid*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Aphakia, B.) Melanoma or a history of melanoma, C.) Invasive squamous cell carcinomas, or D.) History of a light sensitive disease/skin photosensitivity disorder such systemic lupus erythematosus (SLE), porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum or albinism
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Psoriasis, or B.) Vitiligo
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, immunologist, or dermatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# MIGLUSTAT

---

## Products Affected

- *miglustat*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of mild to moderate type 1 Gaucher disease and patient is not a candidate for enzyme replacement therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **MS INTERFERONS**

---

### **Products Affected**

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NATPARA

---

## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hypoparathyroidism and used to control hypocalcemia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **NERLYNX**

---

### **Products Affected**

- NERLYNX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Early stage HER2-positive breast cancer and used following adjuvant trastuzumab therapy, or B.) Advanced or metastatic HER2-positive breast cancer, used in combination with capecitabine, AND patient has received 2 or more prior anti-HER2-based regimens in the metastatic setting
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NICOTINE

---

## Products Affected

- NICOTROL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Beneficiary continues to smoke
<b>Required Medical Information</b>	Beneficiary must have successful cessation at 12 weeks for one additional authorization period of 12 weeks.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 12 weeks, Renewal: 12 weeks (Maximum 24 weeks treatment)
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **NINLARO**

---

### **Products Affected**

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of multiple myeloma, used in combination with lenalidomide and dexamethasone, AND patient has history of at least 1 prior therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NITISINONE

---

## Products Affected

- *nitisinone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hereditary tyrosinemia type 1
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **NUBEQA**

---

### **Products Affected**

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Non-metastatic, castration-resistant prostate cancer, or B.) Metastatic hormone-sensitive prostate cancer in combination with docetaxel
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NUCALA

---

## Products Affected

- NUCALA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Severe asthma with eosinophilic phenotype, B.) Eosinophilic granulomatosis with polyangiitis (EGPA), C.) Hypereosinophilic syndrome lasting at least 6 months without an identifiable non-hematologic secondary cause, or D.) Chronic rhinosinusitis with nasal polyps and used as an adjunct treatment
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# NUEDEXTA

---

## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes, B.) Heart failure, C.) Complete AV block without an implanted pacemaker or high risk of complete AV block, D.) Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozone), E.) Concomitant use with MAOIs or within 14 days of MAOI therapy, F.) History of quinine-, mefloquine-, or quinidine-induced thrombocytopenia, bone marrow depression, or lupus-like syndrome
<b>Required Medical Information</b>	Diagnosis of pseudobulbar affect
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NUPLAZID

---

## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hallucinations and delusions associated with Parkinson disease psychosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# OCTREOTIDE

---

## Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Acromegaly and patient has inadequate response to or is ineligible for surgery, radiation, or bromocriptine mesylate, or B.) Metastatic carcinoid syndrome, or C.) Vasoactive intestinal peptide-secreting tumors (VIPomas) with associated diarrhea
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ODOMZO

---

## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of locally advanced basal cell carcinoma of the skin and one of the following A.) Cancer has recurred following surgery or radiation therapy, B.) Patient is not a candidate for surgery or radiation therapy.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **OFEV**

---

### **Products Affected**

- OFEV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Idiopathic pulmonary fibrosis (IPF), B.) Systemic sclerosis-associated interstitial lung disease (ILD), or C.) Chronic fibrosing interstitial lung disease with a progressive phenotype
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ONUREG

---

## Products Affected

- ONUREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acute myeloid leukemia (AML) used in maintenance treatment for adult patients who achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **OPSUMIT**

---

### **Products Affected**

- OPSUMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension (WHO Group I), confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e. g., patient is frail, elderly, etc.)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ORGOVYX

---

## Products Affected

- ORGOVYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **ORKAMBI**

---

### **Products Affected**

- ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG
- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# OSPHENA

---

## Products Affected

- OSPHENA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Undiagnosed abnormal genital bleeding, B.) Known or suspected estrogen-dependent neoplasia, C.) Active deep vein thrombosis (DVT), pulmonary embolism (PE), or a history of these conditions, D.) Active arterial thromboembolic disease (e.g. stroke, myocardial infarction) or a history of these conditions, or E.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause, or B.) Moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## OXANDROLONE

---

### Products Affected

- *oxandrolone oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Known or suspected carcinoma of the prostate or breast in males, B.) Carcinoma of the breast in females with hypercalcemia, C.) Pregnancy, D.) Nephrosis or nephrotic phase of nephritis, E.) Hypercalcemia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Bone pain associated with osteoporosis, B.) Protein catabolism associated with chronic corticosteroid administration, or C.) Used as adjunctive therapy to promote weight gain after weight loss associated with one of the following 1.) Extensive surgery, 2.) Chronic infections, 3.) Severe trauma, or 4.) Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# PANRETIN

---

## Products Affected

- PANRETIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of AIDS-related Kaposi's sarcoma and both of the following 1.) Used to treat cutaneous lesions, and 2.) Systemic anti-Kaposi's Sarcoma therapy is not indicated (e.g., patient does not have more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or HIV specialist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## PEGYLATED INTERFERON

---

### Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Autoimmune hepatitis, B.) Hepatic decompensation (Child-Pugh score greater than 6 (Class B and C) in cirrhotic patients before treatment, OR hepatic decompensation (Child-Pugh score greater than or equal to 6) in cirrhotic patients co-infected with hepatitis C and HIV before treatment, C.) Hypersensitivity reactions, including urticaria, bronchoconstriction, anaphylaxis, or Stevens-Johnson syndrome to alfa interferons or any component of the product, or D.) Pregnancy with concomitant ribavirin use
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic hepatitis B infection, or B.) Chronic hepatitis C and required criteria will be applied consistent with current AASLD-IDSA guidance with compensated liver disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# PEMAZYRE

---

## Products Affected

- PEMAZYRE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.)Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with confirmed fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test, or B.) Relapsed or refractory myeloid/lymphoid neoplasms with fibroblast growth factor receptor 1 rearrangement
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, gastroenterologist, or hepatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## PHENYL BUTYRATE

---

### Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Management of acute hyperammonemia
<b>Required Medical Information</b>	Diagnosis of urea cycle disorders involving deficiencies of carbamoylphosphate synthetase, ornithine transcarbamoylase, or argininosuccinic acid
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# PIQRAY

## Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hormone receptor (HR) positive, HER2-negative, PIK3CA-mutated, advanced or metastatic breast cancer and must meet all of the following 1.) Used in combination with fulvestrant, 2.) Disease has progressed on or after an endocrine-based regimen, and 3.) Patient is a male or postmenopausal female
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **PIRFENIDONE**

---

### **Products Affected**

- *pirfenidone oral tablet 267 mg, 801 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of idiopathic pulmonary fibrosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# POMALYST

---

## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) AIDS-related Kaposi sarcoma and patient has failure on highly active antiretroviral therapy (HAART), B.) Kaposi sarcoma in HIV-negative adults, or C.) Multiple myeloma and in combination with dexamethasone in adults who have received at least 2 prior therapies (including lenalidomide and a proteasome inhibitor) and have demonstrate disease progression on or within 60 days of completion of the last therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# POSACONAZOLE

---

## Products Affected

- *posaconazole*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Oropharyngeal candidiasis, B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection, or C.) Invasive aspergillosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# POSACONAZOLE SUSPENSION

---

## Products Affected

- NOXAFIL ORAL SUSPENSION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Oropharyngeal candidiasis, B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection, or C.) Invasive aspergillosis
<b>Age Restrictions</b>	13 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **PREVYMIS**

---

### **Products Affected**

- PREVYMIS ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use with pimozide or ergot alkaloids (ergotamine, dihydroergotamine), B.) Concomitant use with pitavastatin or simvastatin when coadministered with cyclosporine
<b>Required Medical Information</b>	Must meet both of the following 1.) Patient is CMV-seropositive (R+) and 2.) Patient is receiving an allogeneic hematopoietic stem cell transplant (HSCT)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# PROMACTA

---

## Products Affected

- PROMACTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic idiopathic thrombocytopenic purpura (ITP), B.) Chronic hepatitis C infection associated thrombocytopenia, or C.) Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with standard immunosuppressive therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **PYRUKYND**

---

### **Products Affected**

- PYRUKYND
- PYRUKYND TAPER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hemolytic anemia with pyruvate kinase (PK) deficiency
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# QINLOCK

---

## Products Affected

- QINLOCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced gastrointestinal stromal tumor (GIST) and patient has received prior treatment with 3 or more kinase inhibitors, including imatinib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **QUININE SULFATE**

---

### **Products Affected**

- *quinine sulfate oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Prolongation of QT interval, B.) Glucose-6-phosphate dehydrogenase deficiency, C.) Myasthenia gravis, D.) Known hypersensitivity to mefloquine or quinidine, E.) Optic neuritis, F.) Diagnosis of Blackwater fever
<b>Required Medical Information</b>	Diagnosis of one of the following A.) uncomplicated Plasmodium falciparum malaria, B.) uncomplicated Plasmodium vivax malaria, or C.) babesiosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# RAVICTI

---

## Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of urea cycle disorders
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **REGRANEX**

---

### **Products Affected**

- REGRANEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Known neoplasm at the site of application
<b>Required Medical Information</b>	Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# REPATHA

---

## Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH), B.) homozygous familial hypercholesterolemia, C.) established cardiovascular disease and myocardial infarction prophylaxis, stroke prophylaxis, or coronary revascularization prophylaxis is required, or D.) clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following 1.) acute coronary syndrome, 2.) history of myocardial infarction, 3.) stable/unstable angina, 4.) coronary or other arterial revascularization, 5.) stroke, 6.) transient ischemic stroke (TIA), or 7.) peripheral arterial disease presumed to be atherosclerotic region
<b>Age Restrictions</b>	10 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **RETEVMO**

---

### **Products Affected**

- RETEVMO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in patients who require systemic therapy, B.) Metastatic RET fusion-positive non-small cell lung cancer (NSCLC), C.) Advanced or metastatic RET fusion-positive thyroid cancer in patients who require systemic therapy and are refractory to radioactive iodine, if appropriate, or D.) Locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# REVLIMID

## Products Affected

- *lenalidomide*
- REVLIMID ORAL CAPSULE 2.5 MG, 20 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Multiple myeloma and medication will be used in combination with dexamethasone, B.) Autologous hematopoietic stem-cell transplantation (HSCT) in multiple myeloma patients, C.) Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality or without additional cytogenetic abnormalities, D.) Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib, E.) Follicular lymphoma and used in combination with rituximab, or F.) Marginal zone lymphoma and used in combination with rituximab
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **REZUROCK**

---

### **Products Affected**

- REZUROCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of chronic graft-vs-host disease in adult and pediatric patients at least 12 years of age after failure of at least 2 prior lines of systemic therapy.
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# RILUZOLE

---

## Products Affected

- *riluzole*
- TIGLUTIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# RINVOQ

---

## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Active psoriatic arthritis, C.) Moderate to severe atopic dermatitis and patient has trial/failure, contraindication, or intolerance to two of the following 1.) Topical corticosteroid and/or 2.) Topical calcineurin inhibitor, D.) Moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more tumor necrosis factor blockers, or E.) Active ankylosing spondylitis who have had an inadequate response or intolerance to one or more tumor necrosis factor blockers
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Screening for latent tuberculosis infection is required prior to initiation of treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ROZLYTREK

---

## Products Affected

- ROZLYTREK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) ROS1-positive metastatic non-small cell lung cancer (NSCLC), or B.) Solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have either progressed following treatment or have no satisfactory alternative therapy
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## RUBRACA

---

### Products Affected

- RUBRACA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Epithelial ovarian, fallopian tube, or primary peritoneal cancer with deleterious BRCA mutation (germline and/or somatic) as detected by an FDA-approved test and patient has been treated with 2 or more prior lines of chemotherapy, B.) Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, used as maintenance treatment, and patient is in complete or partial response to platinum-based chemotherapy, or C.) Deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer and patient has been treated with androgen receptor-directed therapy and a taxane-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# RYDAPT

---

## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation therapy, or B.) systemic mastocytosis or mast cell leukemia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SAPROPTERIN

---

## Products Affected

- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 2 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SCSEMBLIX

---

## Products Affected

- SCSEMBLIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs), or B.) Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) with the T315I mutation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **SIGNIFOR**

---

### **Products Affected**

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Cushing disease and patient has had inadequate response to or is not a candidate for surgery. For renewal: Documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels or improvement in signs or symptoms of the disease
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SILDENAFIL

---

## Products Affected

- *sildenafil citrate oral tablet 20 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Nitrate therapy, including intermittent use, B.) Concomitant use with riociguat or other guanylate cyclase stimulators, C.) Concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension (WHO Group I), confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# SKYRIZI

---

**Products Affected**

- SKYRIZI (150 MG DOSE)
- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe plaque psoriasis and patient is a candidate for systemic therapy or phototherapy, B.) Active psoriatic arthritis in adults, or C.) Moderately to severely active Crohn's disease in adults
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Screening for latent tuberculosis infection is required prior to initiation of treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SOMAVERT

---

## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acromegaly and patient has had an inadequate response to or is ineligible for surgery or radiation therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **SORAFENIB**

---

### **Products Affected**

- *sorafenib tosylate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Squamous cell lung cancer being treated with carboplatin and paclitaxel
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma, B.) Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment, or C.) Unresectable hepatocellular carcinoma
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SPRYCEL

---

## Products Affected

- SPRYCEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, B.) Chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy, C.) Ph+ acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy, or D.) Newly diagnosed Ph+ ALL in combination with chemotherapy
<b>Age Restrictions</b>	1 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# STELARA

---

## Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severely active Crohn disease, B.) Moderate to severe plaque psoriasis, C.) Active psoriatic arthritis, or D.) Moderate to severe active ulcerative colitis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Screening for latent tuberculosis infection is required prior to initiation of treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# STIVARGA

---

## Products Affected

- STIVARGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic colorectal cancer in patients previously treated with fluoropyrimidine, oxaliplatin, and irinotecan containing chemotherapy, anti-VEGF therapy, and if RAS wild type, anti-EGFR therapy, B.) Liver carcinoma in patients previously treated with sorafenib, or C.) Locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with imatinib and sunitinib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **SUNITINIB**

---

### **Products Affected**

- *sunitinib malate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Gastrointestinal stromal tumor after disease progression on or intolerance to imatinib, B.) Pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease, C.) Advanced renal cell carcinoma, or D.) Renal cell carcinoma and used as adjuvant therapy following nephrectomy in patients who are at high risk for recurrence
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SUNOSI

---

## Products Affected

- SUNOSI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use of an MAOI, or B.) Use within 14 days of discontinuing an MAOI
<b>Required Medical Information</b>	Diagnosis of one of the following A.) narcolepsy with excessive daytime drowsiness and has trial of/or contraindication to modafinil or armodafinil, or B.) obstructive sleep apnea (OSA) with excessive daytime drowsiness and has trial of/or contraindication to modafinil or armodafinil
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **SYMDEKO**

---

### **Products Affected**

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (CF) and must meet one of the following 1.) Patient is homozygous for the F508del mutation, or 2.) Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SYMLIN

---

## Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Confirmed diagnosis of gastroparesis, B.) Hypoglycemia unawareness
<b>Required Medical Information</b>	Diagnosis of type 1 or type 2 diabetes mellitus and patient uses mealtime insulin therapy and has failed to achieve desired glucose control
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **SYNAREL**

---

### **Products Affected**

- SYNAREL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) pregnancy, B.) breastfeeding, C.) undiagnosed abnormal vaginal bleeding
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Central precocious puberty, or B.) Endometriosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# SYNRIBO

---

## Products Affected

- SYNRIBO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML) and patient has tried and failed or has a contraindication or intolerance to at least 2 tyrosine kinase inhibitors
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TABRECTA

---

## Products Affected

- TABRECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAFINLAR

---

## Products Affected

- TAFINLAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally advanced or metastatic anaplastic thyroid carcinoma with BRAF V600E mutation, in combination with trametinib and no satisfactory locoregional treatment options, B.) Metastatic non-small cell lung cancer with BRAF V600E mutation, in combination with trametinib or in patients previously treated as monotherapy, C.) Unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutation, or D.) Unresectable or metastatic solid tumors with BRAF V600E mutation, in combination with trametinib, and have progressed following prior treatment and have no satisfactory alternative treatment options
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAGRISSO

---

## Products Affected

- TAGRISSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletion or exon 21 L858R mutation and used as first line therapy, B.) Metastatic non-small cell lung cancer with T790M EGFR mutation (as confirmed by an FDA-approved test) AND whose disease has progressed on or after EGFR tyrosine kinase inhibitor therapy, or C.) Non-small cell lung cancer (NSCLC) with tumor epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations (as confirmed by an FDA-approved test) AND patient requires adjuvant therapy after tumor resection
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAKHZYRO

---

## Products Affected

- TAKHZYRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following and used as routine prophylaxis A.) Hereditary angioedema (HAE) with C1 inhibitor deficiency (Type 1) confirmed by laboratory testing, or B.) HAE with C1 inhibitor dysfunction (Type 2) confirmed by laboratory testing, or C.) HAE with normal C1 inhibitor (Type 3) confirmed by laboratory testing and one of the following 1.) Positive test for an F12, angiotensin-1, or plasminogen gene mutation, or 2.) Family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, immunologist, or allergist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# TALZENNA

---

## Products Affected

- TALZENNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm), human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TASIGNA

---

## Products Affected

- TASIGNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Long QT syndrome, B.) Uncorrected hypokalemia, C.) Uncorrected hypomagnesemia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML), B.) Chronic phase or accelerated phase Philadelphia chromosome-positive CML in a patient with resistance or intolerance to prior therapy that included imatinib, or C.) Chronic phase Philadelphia chromosome-positive CML in a patient with resistance or intolerance to prior tyrosine-kinase inhibitor therapy
<b>Age Restrictions</b>	1 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAVNEOS

---

## Products Affected

- TAVNEOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) in combination with standard therapy including glucocorticoids
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAZAROTENE

---

## Products Affected

- *tazarotene external cream*
- *tazarotene external gel*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Acne vulgaris and patient has trial with at least one generic topical acne product, or B.) Stable moderate to severe plaque psoriasis with 20% or less body surface area involvement and patient has trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs)
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TAZVERIK

---

## Products Affected

- TAZVERIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic or locally advanced epithelioid sarcoma in patients not eligible for complete resection, B.) Relapsed or refractory follicular lymphoma in patients whose tumors are positive for an EZH2 mutation as detected by an FDA-approved test and who have received at least 2 prior systemic therapies, or C.) Relapsed or refractory follicular lymphoma in patients who have no satisfactory alternative treatment options
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TEGSEDI

---

## Products Affected

- TEGSEDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Platelet count less than 100,000 per microliter, B.) Urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
<b>Required Medical Information</b>	Diagnosis of Polyneuropathy of hereditary transthyretin-mediated amyloidosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TEPMETKO

---

## Products Affected

- TEPMETKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TERIPARATIDE

---

## Products Affected

- *teriparatide (recombinant)*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Osteoporosis in postmenopausal female patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate or Tymlos, B.) Primary or hypogonadal osteoporosis in male patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate, or C.) Osteoporosis due to associated sustained systemic glucocorticoid therapy in patient with high risk for fracture and patient has contraindication or has tried/had inadequate response to a bisphosphonate
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 12 months, Renewal: 12 months (Maximum 24 month treatment per patient lifetime)
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## TESTOSTERONES

---

### Products Affected

- testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Carcinoma of the breast (males only), B.) Known or suspected carcinoma of the prostate, C.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hypogonadotropic hypogonadism or B.) Primary hypogonadism. Diagnosis of hypogonadism must be confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TETRABENAZINE

---

## Products Affected

- *tetrabenazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Actively suicidal, B.) Untreated or inadequately treated depression, C.) Impaired hepatic function, D.) Concomitant use of monoamine oxidase inhibitors, E.) Concomitant use of reserpine or within 20 days of discontinuing reserpine
<b>Required Medical Information</b>	Diagnosis of chorea associated with Huntington's disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# THALOMID

---

## Products Affected

- THALOMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Multiple myeloma that is newly diagnosed, or B.) Erythema nodosum leprosum (ENL)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or infectious disease specialist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TIBSOVO

---

## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsed or refractory acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 mutation (as detected by an FDA-approved test), B.) Previously treated, locally advanced or metastatic cholangiocarcinoma with an isocitrate dehydrogenase-1 mutation (as detected by an FDA-approved test.), or C.) Acute myeloid leukemia (newly-diagnosed) with susceptible isocitrate dehydrogenase-1 mutation and meets one of the following: 1.) Patient is 75 years of age or older, or 2.) Patient has comorbidities that preclude intensive induction chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hematologist, hepatologist, or oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOBI

---

## Products Affected

- TOBI PODHALER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Known sensitivity to any aminoglycoside
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (confirmed by appropriate diagnostic or genetic testing) and patient has suspected or confirmed <i>Pseudomonas aeruginosa</i> infection in the lungs
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOLVAPTAN

---

## Products Affected

- *tolvaptan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Diagnosis of Autosomal Dominant Polycystic Kidney Disease (ADPKD), B.) Urgent need to raise serum sodium acutely, C.) Inability to sense or appropriately respond to thirst, D.) Hypovolemic hyponatremia, E.) Concomitant use of strong CYP 3A Inhibitors (e.g. clarithromycin, ketoconazole, ritonavir), or F.) Anuria
<b>Required Medical Information</b>	Diagnosis of clinically significant hypervolemic or euvolemic hyponatremia (serum sodium less than 125 mEq/L or less marks hyponatremia that is symptomatic and has resisted correction with fluid restriction), including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## TOPICAL RETINOIDS

---

### Products Affected

- *adapalene external cream*
- *adapalene external gel 0.3 %*
- *tretinoin external*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of mild to moderate acne vulgaris
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOREMIFENE

---

## Products Affected

- *toremifene citrate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Acquired or congenital long QT syndrome, B.) Uncorrected hypokalemia, C.) Uncorrected hypomagnesemia
<b>Required Medical Information</b>	Diagnosis of metastatic breast cancer and patient must have previous inadequate response or intolerance to tamoxifen
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# TRIENTINE

---

## Products Affected

- *trientine hcl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Wilson's disease in patients that are intolerant to penicillamine
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TRIKAFTA

---

## Products Affected

- TRIKAFTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (CF) and patient has at least 1 F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TRUSELTIQ

---

## Products Affected

- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, gastroenterologist or hepatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TUKYSA

---

## Products Affected

- TUKYSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced unresectable or metastatic HER2-positive breast cancer (including brain metastases) in patients who have received one or more prior anti-HER2-based regimens in the metastatic setting and drug is being used in combination with trastuzumab and capecitabine
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TURALIO

---

## Products Affected

- TURALIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TYMLOS

---

## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of postmenopausal osteoporosis and one of the following A.) osteoporotic fracture or multiple risk factors for fracture, or B.) previous trial of/or contraindication to bisphosphonate
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 12 months, Renewal: 12 months (Maximum 24 month treatment per patient lifetime)
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **UBRELVY**

---

### **Products Affected**

- UBRELVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)
<b>Required Medical Information</b>	Diagnosis of migraine disorder with or without aura and patient has documented trial, inadequate response, or contraindication to at least 1 generic formulary triptan
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VALCHLOR

---

## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cutaneous T-cell lymphoma (stage IA and IB mycosis fungoides-type) and patient has received prior skin-directed therapy (e.g. Topical corticosteroids, phototherapy, or topical nitrogen mustard)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# VENCLEXTA

---

## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A inhibitor during the initial and titration phase in patients with CLL or SLL
<b>Required Medical Information</b>	Diagnosis of one of the following A.) chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), or B.) Newly-diagnosed acute myeloid leukemia (AML) and used in combination with azacitidine, decitabine or low-dose cytarabine in patients 75 years or older or who have comorbidities that preclude use of intensive induction chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VERQUVO

---

## Products Affected

- VERQUVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use of other soluble guanylate cyclase (sGC) stimulators, or B.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of chronic heart failure (HF), NYHA Class II to IV and all of the following 1.) Left ventricular ejection fraction less than 45%, 2.) Previous hospitalization for HF within 6 months or outpatient IV diuretic treatment for HF within 3 months
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VERZENIO

## Products Affected

- VERZENIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer and ALL of the following: 1.) Patient is at high risk of recurrence, 2.) Ki-67 score 20% or higher as determined by an FDA approved test, and 3.) Requested drug will be used in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for adjuvant treatment, OR B.) Advanced or metastatic, HER2-negative, hormone receptor-positive breast cancer AND one of the following: 1.) For postmenopausal women must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy and patient has trial and failure or contraindication to Ibrance or Kisqali, 2.) For premenopausal or perimenopausal women must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy and patient has trial and failure or contraindication to Ibrance, 3.) Used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali, 4.) For men, and postmenopausal women used as initial endocrine-based treatment in combination with an aromatase inhibitor and patient has trial and failure or contraindication to Kisqali or Ibrance, or 5.) For premenopausal or perimenopausal women used as initial endocrine-based treatment in combination with an aromatase inhibitor and patient has trial and failure or contraindication to Kisqali
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VIGABATRIN

---

## Products Affected

- *vigabatrin*
- VIGADRONE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Infantile spasms, or B.) Refractory complex partial seizures and the drug is being used as adjunctive therapy in patients who have responded inadequately to two alternative treatments (i.e. valproic acid, primidone, carbamazepine, phenobarbital, and phenytoin)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VIJOICE

---

## Products Affected

- VIJOICE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) in patients who require systemic therapy
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## VITRAKVI

---

### Products Affected

- VITRAKVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic or surgically unresectable neurotrophic receptor tyrosine kinase (NTRK) gene fusion positive solid tumors and used in patients with unsatisfactory alternative treatments or who have progressed following treatment
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VIZIMPRO

---

## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer with confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# VONJO

---

## Products Affected

- VONJO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of intermediate or high-risk primary or secondary myelofibrosis in adults AND a platelet count less than 50 X 10 <sup>9</sup> /L
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VORICONAZOLE

## Products Affected

- *voriconazole intravenous*
- *voriconazole oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use of carbamazepine, CYP3A4 substrates (e.g., terfenadine, astemizole, cisapride, pimozone, or quinidine), B.) Concomitant use with high-dose ritonavir (400mg every 12 hours), C.) Concomitant use with ergot alkaloids, D.) Concomitant use with long-acting barbiturates, E.) Concomitant use with rifabutin or rifampin, F.) Concomitant use with sirolimus, or G.) Concomitant use with efavirenz at standard doses of 400mg/day or higher
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Invasive aspergillosis, B.) Candidemia, C.) Esophageal Candidiasis, D.) Invasive candidiasis of the skin and abdomen, kidney, bladder wall, and wounds, or E.) Serious fungal infection due to <i>Scedosporium apiospermum</i> or <i>Fusarium</i> species
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	IV formulation: B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VOTRIENT

---

## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma, or B.) Advanced soft tissue sarcoma and patient received at least one prior chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VYNDAMAX

---

## Products Affected

- VYNDAMAX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of wild type or hereditary transthyretin related familial amyloid cardiomyopathy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## WELIREG

---

### Products Affected

- WELIREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of von Hippel-Lindau (VHL) disease who require therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET), not requiring immediate surgery
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XALKORI

---

## Products Affected

- XALKORI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive or ROS1-positive as detected by an FDA-approved test, B.) Relapsed or refractory systemic anaplastic large cell lymphoma that is anaplastic lymphoma kinase (ALK) positive as detected by an FDA-approved test, or C.) Unresectable, recurrent, or refractory inflammatory myofibroblastic tumors that are anaplastic lymphoma kinase (ALK)-positive
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XGEVA

---

## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Hypocalcemia (calcium less than 8.0 mg/dL)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Bone metastases from a solid tumor and used for the prevention of skeletal related events, B.) Multiple myeloma and used for the prevention of skeletal related events, C.) Hypercalcemia of malignancy refractory to bisphosphonate therapy, or D.) Giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XOLAIR

---

## Products Affected

- XOLAIR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic idiopathic urticaria in patients who remain symptomatic despite H1 antihistamine therapy and patient will continue to receive concurrent H1 antihistamine therapy unless contraindicated or not tolerated, B.) Moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms are inadequately controlled with inhaled corticosteroids or an alternative controller medication (i.e. long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) and patient has trial and failure, contraindication, or intolerance to one of the following based on patients age: Dupixent or Nucala, or C.) Nasal polyps in patients with inadequate response to nasal corticosteroids, requested drug will be used as adjunctive treatment, and patient has trial and failure, contraindication, or intolerance to Dupixent
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D determination required per CMS guidance
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# XOSPATA

---

## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XPOVIO

## Products Affected

- XPOVIO (100 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK 50  
MG
- XPOVIO (40 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK 40  
MG
- XPOVIO (40 MG TWICE WEEKLY)  
ORAL TABLET THERAPY PACK 40  
MG
- XPOVIO (60 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK 60  
MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)  
ORAL TABLET THERAPY PACK 40  
MG
- XPOVIO (80 MG TWICE WEEKLY)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsed or refractory multiple myeloma being used in combination with dexamethasone in a patient who has received at least 4 prior therapies and is refractory to at least 2 proteasome inhibitors, at least 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody, B.) Multiple myeloma being used in combination with bortezomib and dexamethasone in a patient who has received at least 1 prior therapy, C.) Relapsed or refractory diffuse large B-cell lymphoma not otherwise specified, or D.) Relapsed or refractory DLBCL arising from follicular lymphoma and patient has received at least 2 lines of systemic therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# **XTANDI**

---

## **Products Affected**

- XTANDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Castration-resistant prostate cancer, or B.) Metastatic, castration-sensitive prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XURIDEN

---

## Products Affected

- XURIDEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hereditary orotic aciduria
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# **XYREM**

---

## **Products Affected**

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sedative hypnotic agents, B.) Succinic semialdehyde dehydrogenase deficiency
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Narcolepsy with excessive daytime drowsiness and has trial of/or contraindication to a central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate) or a CNS wakefulness promoting drug (e.g., armodafinil, modafinil), or B.) Cataplexy and narcolepsy
<b>Age Restrictions</b>	7 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XYWAV

---

## Products Affected

- XYWAV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sedative hypnotic agents, B.) Succinic semialdehyde dehydrogenase deficiency
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Narcolepsy with excessive daytime drowsiness and has trial of/or contraindication to a central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate) or a CNS wakefulness promoting drug (e.g., armodafinil, modafinil), or B.) Cataplexy and narcolepsy, or C.) Idiopathic hypersomnia
<b>Age Restrictions</b>	7 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# YONSA

---

## Products Affected

- YONSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of metastatic, castration-resistant prostate cancer and use in combination with methylprednisolone
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ZARXIO

---

## Products Affected

- ZARXIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chemotherapy induced febrile neutropenia (prophylaxis), B.) Severe chronic neutropenia, C.) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, or D.) Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



## **ZEJULA**

---

### **Products Affected**

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and used as maintenance therapy in a patient who is in a complete or partial response to platinum-based chemotherapy, or B.) Advanced ovarian, fallopian tube, or primary peritoneal cancer and patient has been treated with 3 or more prior chemotherapy regimens, and cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability, and disease has progressed more than 6 months after response to the last platinum-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or gynecologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ZELBORAF

---

## Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation documented by an FDA-approved test, or B.) Erdheim-Chester disease and patient has documented BRAF V600 mutation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ZIEXTENZO

---

## Products Affected

- ZIEXTENZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of a non-myeloid malignancy and drug is being used as prophylaxis for chemotherapy-induced neutropenia
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ZOLINZA

---

## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of primary cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent or recurrent disease on or following two systemic therapies (e.g., bexarotene, romidepsin, etc)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## ZYDELIG

---

### Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of toxic epidermal necrosis with any drug
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic lymphocytic leukemia, used in combination with rituximab and patient has relapsed on at least one prior therapy, B.) Non-Hodgkins lymphoma (Follicular, B-Cell) and the patient has relapsed on at least two prior systemic therapies, or C.) Small lymphocytic lymphoma and the patient has relapsed on at least two prior systemic therapies
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ZYKADIA

---

## Products Affected

- ZYKADIA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## **PART B VERSUS PART D**

---

### **Products Affected**

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- *amphotericin b intravenous solution reconstituted 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- AZASAN ORAL TABLET 100 MG, 75 MG
- *azathioprine oral tablet 100 mg, 50 mg, 75 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *calcitonin (salmon) nasal solution 200 unit/act*
- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- *caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg*
- *cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- *cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg*
- CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *colistimethate sodium (cba) injection solution reconstituted 150 mg*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclophosphamide oral tablet 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dextrose intravenous solution 10 %, 5 %*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- ENGERIX-B INJECTION SUSPENSION 20 MCG/ML
- ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg*
- FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL

- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl oral tablet 1 mg*
- IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 50000000 UNIT
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- ISOLYTE-P IN D5W INTRAVENOUS SOLUTION
- ISOLYTE-S PH 7.4 INTRAVENOUS SOLUTION
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 50 mg/2ml*
- *methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NUTRILIPID INTRAVENOUS EMULSION 20 %
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- *pentamidine isethionate injection solution reconstituted 300 mg*
- PLASMA-LYTE 148 INTRAVENOUS SOLUTION
- PLASMA-LYTE A INTRAVENOUS SOLUTION
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- *prednisolone oral solution 15 mg/5ml*
- *prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml*
- *prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg*
- PREDNISON INTENSOL ORAL CONCENTRATE 5 MG/ML
- *prednisone oral solution 5 mg/5ml*
- *prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg*
- *prehevbrio intramuscular suspension 10 mcg/ml*
- PREMASOL INTRAVENOUS SOLUTION 10 %
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PROSOL INTRAVENOUS SOLUTION 20 %
- PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML
- RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML
- *sirolimus oral solution 1 mg/ml*



## ***My Choice Wisconsin***

*Prior Authorization 2022*

*Last Updated 11/24/2022*

- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)
- *tigecycline intravenous solution reconstituted 50 mg*
- *tobramycin inhalation nebulization solution 300 mg/5ml*
- TPN ELECTROLYTES INTRAVENOUS CONCENTRATE
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG
- TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- XATMEP ORAL SOLUTION 2.5 MG/ML

### **Details**

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

## Index

### A

ABELCET INTRAVENOUS  
SUSPENSION 5 MG/ML..... 247  
abiraterone acetate ..... 1  
acetylcysteine inhalation solution 10 %, 20  
% ..... 247  
acitretin ..... 2  
ACTIMMUNE..... 3  
acyclovir sodium intravenous solution 50  
mg/ml ..... 247  
adapalene external cream ..... 207  
adapalene external gel 0.3 % ..... 207  
adefovir dipivoxil..... 80  
ADEMPAS ..... 4  
albuterol sulfate inhalation nebulization  
solution (2.5 mg/3ml) 0.083%, 0.63  
mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml .. 247  
ALECENSA..... 5  
ALUNBRIG..... 7  
AMBISOME INTRAVENOUS  
SUSPENSION RECONSTITUTED 50  
MG ..... 247  
ambrisentan ..... 8  
amphotericin b intravenous solution  
reconstituted 50 mg..... 247  
apomorphine hcl subcutaneous ..... 9  
aprepitant oral capsule 125 mg, 40 mg, 80 &  
125 mg, 80 mg ..... 247  
ARCALYST ..... 10  
ARIKAYCE..... 11  
armodafinil ..... 33  
AURYXIA ..... 12  
AUSTEDO..... 13  
AVONEX PEN INTRAMUSCULAR  
AUTO-INJECTOR KIT..... 129  
AVONEX PREFILLED  
INTRAMUSCULAR PREFILLED  
SYRINGE KIT..... 129  
AYVAKIT ..... 14  
AZASAN ORAL TABLET 100 MG, 75  
MG ..... 247  
azathioprine oral tablet 100 mg, 50 mg, 75  
mg ..... 247

### B

BALVERSA ..... 15  
BARACLUDGE ORAL SOLUTION ..... 80  
BENLYSTA SUBCUTANEOUS..... 16  
BESREMI ..... 17  
BETASERON SUBCUTANEOUS KIT 129  
bexarotene ..... 18, 19  
bosentan ..... 20  
BOSULIF..... 21  
BRAFTOVI ORAL CAPSULE 75 MG ... 22  
BRUKINSA ..... 23  
budesonide inhalation suspension 0.25  
mg/2ml, 0.5 mg/2ml, 1 mg/2ml ..... 247  
BYLVAY ..... 24  
BYLVAY (PELLETS) ORAL CAPSULE  
SPRINKLE 200 MCG ..... 24  
C  
CABLIVI ..... 25  
CABOMETYX ..... 26  
calcitonin (salmon) nasal solution 200  
unit/act..... 247  
calcitriol oral capsule 0.25 mcg, 0.5 mcg 247  
calcitriol oral solution 1 mcg/ml ..... 247  
CALQUENCE ..... 27  
CAMZYOS ..... 28  
CAPRELSA ..... 29  
carglumic acid oral tablet soluble ..... 30  
caspofungin acetate intravenous solution  
reconstituted 50 mg, 70 mg..... 247  
CAYSTON..... 31  
cefoxitin sodium intravenous solution  
reconstituted 1 gm, 10 gm, 2 gm..... 247  
chlorpromazine hcl oral tablet 10 mg, 25 mg  
..... 247  
cinacalcet hcl oral tablet 30 mg, 60 mg, 90  
mg ..... 247  
CLINIMIX E/DEXTROSE (2.75/5)  
INTRAVENOUS SOLUTION 2.75 % 247  
CLINIMIX E/DEXTROSE (4.25/10)  
INTRAVENOUS SOLUTION 4.25 % 247  
CLINIMIX E/DEXTROSE (4.25/5)  
INTRAVENOUS SOLUTION 4.25 % 247  
CLINIMIX E/DEXTROSE (5/15)  
INTRAVENOUS SOLUTION 5 % .... 247

# **My Choice Wisconsin**

*Prior Authorization 2022*

*Last Updated 11/24/2022*

CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 % ....	247	deferasirox oral tablet soluble .....	43
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	247	deferiprone .....	44
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	247	dextrose intravenous solution 10 %, 5 %	247
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 % ....	247	DIACOMIT.....	45
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 % ....	247	diclofenac sodium external gel 3 % .....	46
CLINISOL SF INTRAVENOUS SOLUTION 15 % .....	247	dimethyl fumarate oral.....	47
colistimethate sodium (cba) injection solution reconstituted 150 mg.....	247	dimethyl fumarate starter pack.....	47
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG .....	34	diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml.....	247
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG .....	34	DOJOLVI.....	48
COMETRIQ (60 MG DAILY DOSE).....	34	dronabinol .....	49
COPIKTRA.....	35	droxidopa .....	50
CORLANOR ORAL TABLET .....	36	DUPIXENT.....	51
COSENTYX (300 MG DOSE).....	37	<b>E</b>	
COSENTYX SENSOREADY (300 MG). 37		ELIGARD .....	112
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML .....	37	EMGALITY .....	52
COTELLIC .....	38	ENBREL MINI.....	53
cromolyn sodium inhalation nebulization solution 20 mg/2ml .....	247	ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML .....	53
cyclophosphamide oral capsule 25 mg, 50 mg .....	247	ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE .....	53
cyclophosphamide oral tablet 25 mg, 50 mg .....	247	ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR .....	53
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg .....	247	ENDARI .....	54
cyclosporine modified oral solution 100 mg/ml .....	247	ENGERIX-B INJECTION SUSPENSION 20 MCG/ML .....	247
cyclosporine oral capsule 100 mg, 25 mg	247	ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML .....	247
CYSTADROPS.....	40	ENSPRYNG .....	55
CYSTAGON.....	39	entecavir .....	80
CYSTARAN.....	40	ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG .....	247
<b>D</b>		EPIDIOLEX.....	56
dalfampridine er .....	41	ERIVEDGE.....	58
DAURISMO .....	42	ERLEADA .....	59
deferasirox oral tablet .....	43	erlotinib hcl .....	60
		ESBRIET ORAL CAPSULE.....	61
		everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg .....	247
		everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg .....	62
		everolimus oral tablet soluble .....	63
		EVRYSDI .....	64

EXKIVITY .....	65	HUMIRA PEN-PS/UV/ADOL HS START	
<b>F</b>		SUBCUTANEOUS PEN-INJECTOR	
febuxostat.....	66	KIT 40 MG/0.8ML .....	83
fentanyl .....	68	HUMIRA PEN-PSOR/UEIT STARTER	
fentanyl citrate buccal lozenge on a handle		.....	83
.....	67	HUMIRA SUBCUTANEOUS PREFILLED	
FERRIPROX ORAL SOLUTION.....	44	SYRINGE KIT 10 MG/0.1ML, 20	
FINTEPLA.....	69	MG/0.2ML, 40 MG/0.4ML, 40	
FIRAZYR .....	86	MG/0.8ML .....	83
FIRMAGON (240 MG DOSE)		HYFTOR.....	84
SUBCUTANEOUS SOLUTION		<b>I</b>	
RECONSTITUTED 120 MG/VIAL... 247		IBRANCE.....	85
FIRMAGON SUBCUTANEOUS		ICLUSIG.....	87
SOLUTION RECONSTITUTED 80 MG		IDHIFA .....	88
.....	247	imatinib mesylate .....	89
FOTIVDA .....	70	IMBRUVICA.....	90
<b>G</b>		IMOVAX RABIES INTRAMUSCULAR	
GALAFOLD.....	71	SUSPENSION RECONSTITUTED 2.5	
GAMMAGARD INJECTION SOLUTION		UNIT/ML.....	248
2.5 GM/25ML.....	248	INCRELEX.....	91
GAMMAGARD S/D LESS IGA		INLYTA.....	92
INTRAVENOUS SOLUTION		INQOVI .....	93
RECONSTITUTED 10 GM, 5 GM .... 248		INREBIC.....	94
GAMUNEX-C INJECTION SOLUTION 1		INTRALIPID INTRAVENOUS	
GM/10ML.....	248	EMULSION 20 %, 30 % .....	248
GATTEX.....	72	INTRAROSA.....	95
GAVRETO .....	73	INTRON A INJECTION SOLUTION	
GENGRAF ORAL CAPSULE 100 MG, 25		RECONSTITUTED 10000000 UNIT,	
MG .....	248	50000000 UNIT .....	248
GENGRAF ORAL SOLUTION 100		ipratropium bromide inhalation solution	
MG/ML.....	248	0.02 % .....	248
GILENYA ORAL CAPSULE 0.5 MG.....	74	ipratropium-albuterol inhalation solution	
GILOTRIF .....	75	0.5-2.5 (3) mg/3ml .....	248
glatiramer acetate .....	76	IRESSA.....	96
granisetron hcl oral tablet 1 mg .....	248	ISOLYTE-P IN D5W INTRAVENOUS	
guanfacine hcl er.....	79	SOLUTION.....	248
<b>H</b>		ISOLYTE-S PH 7.4 INTRAVENOUS	
HETLIOZ.....	82	SOLUTION.....	248
HUMIRA PEDIATRIC CROHNS START		ISTURISA.....	97
SUBCUTANEOUS PREFILLED		itraconazole oral.....	98, 99
SYRINGE KIT 80 MG/0.8ML, 80		ivermectin oral .....	100
MG/0.8ML & 40MG/0.4ML .....	83	<b>J</b>	
HUMIRA PEN SUBCUTANEOUS PEN-		JAKAFI.....	101
INJECTOR KIT .....	83	<b>K</b>	
HUMIRA PEN-CD/UC/HS STARTER ... 83		KALYDECO.....	102
HUMIRA PEN-PEDIATRIC UC START 83		KESIMPTA.....	103

# My Choice Wisconsin

Prior Authorization 2022

Last Updated 11/24/2022

KISQALI (200 MG DOSE).....	104	methotrexate sodium (pf) injection solution	
KISQALI (400 MG DOSE).....	104	50 mg/2ml .....	248
KISQALI (600 MG DOSE).....	104	methotrexate sodium injection solution 50	
KISQALI FEMARA (400 MG DOSE) ..	105	mg/2ml .....	248
KISQALI FEMARA (600 MG DOSE) ..	105	methoxsalen rapid .....	127
KISQALI FEMARA(200 MG DOSE) ...	105	methylprednisolone oral tablet 16 mg, 32	
KORLYM .....	106	mg, 4 mg, 8 mg .....	248
KOSELUGO .....	107	miglustat.....	128
<b>L</b>		modafinil .....	33
lapatinib ditosylate .....	108	mycophenolate mofetil oral capsule 250 mg	
lenalidomide.....	109, 166	.....	248
LENVIMA (10 MG DAILY DOSE) .....	110	mycophenolate mofetil oral suspension	
LENVIMA (12 MG DAILY DOSE) .....	110	reconstituted 200 mg/ml .....	248
LENVIMA (14 MG DAILY DOSE) .....	110	mycophenolate mofetil oral tablet 500 mg	
LENVIMA (18 MG DAILY DOSE) .....	110	.....	248
LENVIMA (20 MG DAILY DOSE) .....	110	mycophenolate sodium oral tablet delayed	
LENVIMA (24 MG DAILY DOSE) .....	110	release 180 mg, 360 mg .....	248
LENVIMA (4 MG DAILY DOSE) .....	110	<b>N</b>	
LENVIMA (8 MG DAILY DOSE) .....	110	NATPARA.....	130
LEUKINE INJECTION SOLUTION		NERLYNX .....	131
RECONSTITUTED.....	111	NICOTROL .....	132
leuprolide acetate injection .....	112	NINLARO.....	133
lidocaine external patch 5 % .....	113	nitisinone.....	134
linezolid intravenous solution 600 mg/300ml		NOXAFIL ORAL SUSPENSION.....	156
.....	114	NUBEQA.....	135
linezolid oral .....	114	NUCALA.....	136
LIVMARLI.....	115	NUEDEXTA.....	137
LIVTENCITY.....	116	NUPLAZID ORAL CAPSULE.....	138
LONSURF .....	117	NUPLAZID ORAL TABLET 10 MG....	138
LORBRENA.....	118	NUTRILIPID INTRAVENOUS	
LUMAKRAS .....	119	EMULSION 20 %.....	248
LUPKYNIS.....	120	<b>O</b>	
LUPRON DEPOT (1-MONTH).....	112	octreotide acetate injection solution 100	
LUPRON DEPOT (3-MONTH).....	112	mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50	
LUPRON DEPOT (4-MONTH).....	112	mcg/ml, 500 mcg/ml .....	139
LUPRON DEPOT (6-MONTH).....	112	ODOMZO .....	140
LYNPARZA ORAL TABLET.....	121, 122	OFEV .....	141
<b>M</b>		OMNITROPE SUBCUTANEOUS	
MATULANE .....	123	SOLUTION CARTRIDGE.....	77, 78
MAVYRET.....	81	OMNITROPE SUBCUTANEOUS	
MAYZENT.....	124	SOLUTION RECONSTITUTED... ..	77, 78
MAYZENT STARTER PACK.....	124	ondansetron hcl oral solution 4 mg/5ml..	248
MEKINIST .....	125	ondansetron hcl oral tablet 4 mg, 8 mg...	248
MEKTOVI.....	126	ondansetron oral tablet dispersible 4 mg, 8	
methotrexate oral tablet 2.5 mg .....	248	mg .....	248

ONUREG.....	142	PREMASOL INTRAVENOUS SOLUTION	
OPSUMIT.....	143	10 % .....	248
ORGOVYX.....	144	PREVYMIS ORAL .....	157
ORKAMBI ORAL PACKET 100-125 MG,		PROGRAF ORAL PACKET 0.2 MG, 1 MG	
150-188 MG.....	145	.....	248
ORKAMBI ORAL TABLET .....	145	PROLASTIN-C INTRAVENOUS	
OSPHENA .....	146	SOLUTION RECONSTITUTED.....	6
oxandrolone oral .....	147	PROMACTA .....	158
<b>P</b>		PROSOL INTRAVENOUS SOLUTION 20	
PANRETIN.....	148	% .....	248
paricalcitol oral capsule 1 mcg, 2 mcg, 4		PULMOZYME INHALATION	
mcg.....	248	SOLUTION 2.5 MG/2.5ML.....	248
PEGASYS SUBCUTANEOUS SOLUTION		PYRUKYND .....	159
180 MCG/ML .....	149	PYRUKYND TAPER PACK.....	159
PEGASYS SUBCUTANEOUS SOLUTION		<b>Q</b>	
PREFILLED SYRINGE .....	149	QINLOCK.....	160
PEMAZYRE.....	150	quinine sulfate oral.....	161
pentamidine isethionate inhalation solution		<b>R</b>	
reconstituted 300 mg.....	248	RABAVERT INTRAMUSCULAR	
pentamidine isethionate injection solution		SUSPENSION RECONSTITUTED... ..	248
reconstituted 300 mg.....	248	RAVICTI .....	162
PIQRAY (200 MG DAILY DOSE).....	152	RECOMBIVAX HB INJECTION	
PIQRAY (250 MG DAILY DOSE).....	152	SUSPENSION 10 MCG/ML, 40	
PIQRAY (300 MG DAILY DOSE).....	152	MCG/ML, 5 MCG/0.5ML .....	248
pirfenidone oral tablet 267 mg, 801 mg..	153	RECOMBIVAX HB INJECTION	
PLASMA-LYTE 148 INTRAVENOUS		SUSPENSION PREFILLED SYRINGE	
SOLUTION.....	248	10 MCG/ML, 5 MCG/0.5ML .....	248
PLASMA-LYTE A INTRAVENOUS		REGRANEX.....	163
SOLUTION.....	248	REPATHA .....	164
PLENAMINE INTRAVENOUS		REPATHA PUSHTRONEX SYSTEM..	164
SOLUTION 15 % .....	248	REPATHA SURECLICK.....	164
POMALYST .....	154	RETACRIT INJECTION SOLUTION	
posaconazole .....	155	10000 UNIT/ML, 10000	
prednisolone oral solution 15 mg/5ml ...	248	UNIT/ML(1ML), 2000 UNIT/ML, 20000	
prednisolone sodium phosphate oral solution		UNIT/ML, 3000 UNIT/ML, 4000	
10 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5		UNIT/ML, 40000 UNIT/ML .....	57
base) mg/5ml.....	248	RETEVMO .....	165
prednisolone sodium phosphate oral tablet		REVLIMID ORAL CAPSULE 2.5 MG, 20	
dispersible 10 mg, 15 mg, 30 mg.....	248	MG .....	166
PREDNISON INTENSOL ORAL		REZUROCK.....	167
CONCENTRATE 5 MG/ML.....	248	riluzole .....	168
prednisone oral solution 5 mg/5ml .....	248	RINVOQ.....	169
prednisone oral tablet 1 mg, 10 mg, 2.5 mg,		ROZLYTREK.....	170
20 mg, 5 mg, 50 mg .....	248	RUBRACA .....	171
prehevbrio intramuscular suspension 10		RYDAPT.....	172
mcg/ml .....	248		

# My Choice Wisconsin

Prior Authorization 2022

Last Updated 11/24/2022

## S

sapropterin dihydrochloride oral packet .	173
sapropterin dihydrochloride oral tablet...	173
SCEMBLIX .....	174
SIGNIFOR .....	175
sildenafil citrate oral tablet 20 mg .....	176
sirolimus oral solution 1 mg/ml .....	248
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	248
SKYRIZI (150 MG DOSE) .....	177
SKYRIZI PEN .....	177
SKYRIZI SUBCUTANEOUS.....	177
sodium phenylbutyrate oral powder 3 gm/tp	
.....	151
sodium phenylbutyrate oral tablet.....	151
sofosbuvir-velpatasvir.....	81
SOMAVERT.....	178
sorafenib tosylate .....	179
SPRYCEL.....	180
STELARA SUBCUTANEOUS	
SOLUTION 45 MG/0.5ML .....	181
STELARA SUBCUTANEOUS	
SOLUTION PREFILLED SYRINGE	181
STIVARGA .....	182
sunitinib malate.....	183
SUNOSI .....	184
SYMDEKO.....	185
SYMLINPEN 120 SUBCUTANEOUS	
SOLUTION PEN-INJECTOR.....	186
SYMLINPEN 60 SUBCUTANEOUS	
SOLUTION PEN-INJECTOR.....	186
SYNAREL .....	187
SYNRIBO .....	188

## T

TABRECTA .....	189
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	
.....	249
TAFINLAR.....	190
TAGRISO .....	191
TAKHZYRO.....	192
TALZENNA .....	193
TASIGNA .....	194
TAVNEOS .....	195
tazarotene external cream .....	196
tazarotene external gel .....	196

TAZORAC EXTERNAL CREAM 0.05 %	
.....	196
TAZORAC EXTERNAL GEL.....	196
TAZVERIK.....	197
TDVAX INTRAMUSCULAR	
SUSPENSION 2-2 LFU/0.5ML .....	249
TEGSEDI.....	198
TENIVAC INTRAMUSCULAR	
INJECTABLE 5-2 LFU, 5-2 LFU	
(INJECTION) .....	249
TEPMETKO .....	199
teriparatide (recombinant).....	200
testosterone transdermal gel 10 mg/act (2%),	
12.5 mg/act (1%), 20.25 mg/1.25gm	
(1.62%), 20.25 mg/act (1.62%), 25	
mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%),	
50 mg/5gm (1%) .....	201
tetrabenazine .....	202
THALOMID .....	203
TIBSOVO .....	204
tigecycline intravenous solution	
reconstituted 50 mg.....	249
TIGLUTIK.....	168
TOBI PODHALER.....	205
tobramycin inhalation nebulization solution	
300 mg/5ml .....	249
tolvaptan.....	206
toremifene citrate .....	208
TPN ELECTROLYTES INTRAVENOUS	
CONCENTRATE .....	249
TRAVASOL INTRAVENOUS SOLUTION	
10 % .....	249
TRELSTAR MIXJECT	
INTRAMUSCULAR SUSPENSION	
RECONSTITUTED 11.25 MG, 22.5 MG,	
3.75 MG .....	249
tretinoin external .....	207
TREXALL ORAL TABLET 10 MG, 15	
MG, 5 MG, 7.5 MG .....	249
trientine hcl .....	209
TRIKAFTA.....	210
TROPHAMINE INTRAVENOUS	
SOLUTION 10 % .....	249
TRUSELTIQ (100MG DAILY DOSE)..	211
TRUSELTIQ (125MG DAILY DOSE)..	211

TRUSELTIQ (50MG DAILY DOSE)....	211	XGEVA.....	231
TRUSELTIQ (75MG DAILY DOSE)....	211	XOLAIR .....	232
TUKYSA .....	212	XOSPATA .....	233
TURALIO .....	213	XPOVIO (100 MG ONCE WEEKLY)	
TYMLOS .....	214	ORAL TABLET THERAPY PACK 50	
<b>U</b>		MG .....	234
UBRELVY .....	215	XPOVIO (40 MG ONCE WEEKLY) ORAL	
<b>V</b>		TABLET THERAPY PACK 40 MG..	234
VALCHLOR.....	216	XPOVIO (40 MG TWICE WEEKLY)	
varenicline tartrate oral tablet .....	32	ORAL TABLET THERAPY PACK 40	
varenicline tartrate oral tablet therapy pack		MG .....	234
.....	32	XPOVIO (60 MG ONCE WEEKLY) ORAL	
VENCLEXTA.....	217	TABLET THERAPY PACK 60 MG..	234
VENCLEXTA STARTING PACK .....	217	XPOVIO (60 MG TWICE WEEKLY)...	234
VERQUVO .....	218	XPOVIO (80 MG ONCE WEEKLY) ORAL	
VERZENIO.....	219, 220	TABLET THERAPY PACK 40 MG..	234
vigabatrin .....	221	XPOVIO (80 MG TWICE WEEKLY)...	234
VIGADRONE.....	221	XTANDI .....	235
VIJOICE .....	222	XURIDEN.....	236
VITRAKVI .....	223	XYREM .....	237
VIZIMPRO .....	224	XYWAV .....	238
VONJO .....	225	<b>Y</b>	
voriconazole intravenous .....	226	YONSA.....	239
voriconazole oral.....	226	<b>Z</b>	
VOSEVI.....	81	ZARXIO .....	240
VOTRIENT.....	227	ZEJULA .....	241
VYNDAMAX.....	228	ZELBORAF.....	242
<b>W</b>		ZIEXTENZO .....	243
WELIREG.....	229	ZOLINZA .....	244
<b>X</b>		ZYDELIG .....	245
XALKORI.....	230	ZYKADIA ORAL TABLET .....	246
XATMEP ORAL SOLUTION 2.5 MG/ML			
.....	249		