

ABILIFY ASIMTUFII

Products Affected

- Abilify Asimtufii

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral aripiprazole has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ABILIFY MYCITE

Products Affected

- Abilify Mycite Maintenance Kit
- Abilify Mycite Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to brand Vraylar. For maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone. For adjunctive treatment of major depressive disorder (MDD): 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Rexulti, Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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ABIRATERONE

Products Affected

- Abiraterone Acetate

- Zytiga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer and very-high-risk prostate cancer.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)
Exclusion Criteria	N/A
Required Medical Information	Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate or cyclosporine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ACTEMRA

Products Affected

- Actemra

- Actemra Actpen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Castleman's disease
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active systemic juvenile idiopathic arthritis (JIA) (new starts only): 1) patient has experienced an inadequate treatment response to a nonsteroidal anti-inflammatory drug (NSAID) trial, a corticosteroid, methotrexate, or leflunomide, OR 2) inadequate treatment response or intolerance to a prior biologic DMARD. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ACTHAR HP

Products Affected

- Acthar

- Acthar Gel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the following diagnoses, patient has experienced an inadequate treatment response to a parenteral or an oral glucocorticoid (for ophthalmic diseases only, inadequate response to a trial of a topical ophthalmic glucocorticoid is also acceptable): 1) For rheumatic disorders (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): The requested drug must be used as adjunctive treatment, 2) For nephrotic syndrome: the requested drug must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic diseases (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic diseases, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness. For infantile spasms (IS): for continuation of therapy, patient must show substantial clinical benefit from therapy.
Age Restrictions	For infantile spasms (IS) initial request: patient is less than 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	IS: 6 months. MS exacerbation: 3 wks. Serum sickness: 1 month. All other diagnoses: 3 months
Other Criteria	N/A

ACTIMMUNE

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides, Sezary syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADAKVEO

Products Affected

- Adakveo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

ADALIMUMAB AET

Products Affected

- Abrilada
- Abrilada 1-pen Kit
- Adalimumab-aaty 1-pen Kit
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe Kit
- Adalimumab-adaz
- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis
- Adalimumab-fkjp
- Adalimumab-ryvk
- Adalimumab-ryvk (2 Pen)
- Amjevita
- Cyltezo
- Cyltezo Starter Package For Crohns Disease/uc/hs
- Cyltezo Starter Package For Psoriasis
- Cyltezo Starter Package For Psoriasis/uveitis
- Hadlima
- Hadlima Pushtouch
- Hulio
- Hyrimoz
- Hyrimoz Crohn's Disease And Ulcerative Colitis Starter Pack
- Hyrimoz Pediatric Crohns Disease Starter Pack
- Hyrimoz Pediatric Crohn'sdisease Starter Pack
- Hyrimoz Plaque Psoriasis/uveitis Starter Pack
- Simlandi 1-pen Kit
- Simlandi 2-pen Kit
- Yuflyma 1-pen Kit
- Yuflyma 2-syringe Kit
- Yuflyma Cd/uc/hs Starter
- Yusimry

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-radiographic axial spondyloarthritis, Behcet's syndrome
Exclusion Criteria	N/A

Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab). For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	<p>For an adult with moderately to severely active Crohn's disease (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab). For active psoriatic arthritis (PsA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderate to severe hidradenitis suppurativa, Behcet's, and non-infectious intermediate, posterior or panuveitis: (new starts only): patient has experienced an intolerable adverse event and that adverse event was NOT attributed to the active ingredient as described in the prescribing information to one of the following: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).</p>
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ADAPALENE

Products Affected

- Adapalene CREA
- Adapalene GEL
- Adapalene PADS
- Adapalene SOLN
- Adapalene Pump
- Adapalene/benzoyl Peroxide
- Cabtreo
- Differin CREA
- Differin GEL 0.3%
- Differin LOTN
- Epiduo
- Epiduo Forte

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For atopic dermatitis, initial therapy: 1) patient has moderate-to-severe disease, AND 2) patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For atopic dermatitis, continuation of therapy: the patient achieved or maintained positive clinical response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 4 months, Continuation: Plan Year
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADLARITY

Products Affected

- Adlarity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Vascular dementia
Exclusion Criteria	N/A
Required Medical Information	Patient is unable to take oral dosage forms (e.g., difficulty swallowing tablets or capsules). For dementia of the Alzheimer's type: the patient has experienced an inadequate response, intolerance, or the patient has a contraindication to rivastigmine transdermal patch.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADZYNMA

Products Affected

- Adzynma

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For congenital thrombotic thrombocytopenic purpura (cTTP), initial: Diagnosis has been confirmed by genetic testing or enzyme assay with biallelic mutations in the ADAMTS13 gene. For cTTP, continuation: Patient is responding to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

AGAMREE

Products Affected

- Agamree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of Duchenne muscular dystrophy (DMD): 1) The diagnosis was confirmed by genetic testing identifying a disease-causing mutation of the DMD gene AND 2) The patient has tried prednisone and experienced any of the following a) unmanageable and/or clinically significant weight gain/obesity, b) unmanageable and/or clinically significant psychiatric/behavioral issues such as abnormal behavior, aggression, or irritability, or c) clinically significant growth stunting.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

AJOVY

Products Affected

- Ajovy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

AKEEGA

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AKLIEF

Products Affected

- Aklied

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mucopolysaccharidosis I (MPS I): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing. Patients with Scheie form (i.e., attenuated MPS I) must have moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large-cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic OR 2) the requested drug will be used as adjuvant treatment following tumor resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALIQOPA

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous), nodal marginal zone lymphoma, splenic marginal zone lymphoma
Exclusion Criteria	N/A
Required Medical Information	For follicular lymphoma, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous), nodal marginal zone lymphoma, and splenic marginal zone lymphoma: 1) the disease is relapsed or refractory AND 2) the requested drug will be used as subsequent therapy after at least 2 prior therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALKINDI

Products Affected

- Alkindi Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For adrenocortical insufficiency: 1) Patient requires a strength that is not available in hydrocortisone tablets (e.g., 0.5 mg, 1 mg, or 2 mg) OR 2) Patient has difficulty swallowing hydrocortisone tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALOSETRON

Products Affected

- Alosetron Hydrochloride
- Lotronex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALPHA1-PROTEINASE INHIBITOR

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha 1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, inflammatory myofibroblastic tumors (IMT) with ALK translocation.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALVAIZ

Products Affected

- Alvaiz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): the requested drug is used for initiation and maintenance of interferon-based therapy. For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): Pt had an insufficient response to immunosuppressive therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks

Other Criteria	For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).
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ALYMSYS

Products Affected

- Alymsys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

AMBRISENTAN

Products Affected

- Ambrisentan

- Letairis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AMITIZA AET

Products Affected

- Amitiza

- Lubiprostone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Idiopathic Constipation (CIC) and Irritable Bowel Syndrome with Constipation (IBS-C): The patient experienced an inadequate treatment response, intolerance, or has a contraindication that would prohibit a trial of Linzess (linaclotide). Opioid-Induced Constipation (OIC): The patient experienced an inadequate treatment response, intolerance, or has a contraindication that would prohibit a trial of Movantik (naloxegol).
Age Restrictions	Irritable Bowel Syndrome with Constipation (IBS-C): 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AMONDYS 45

Products Affected

- Amondys 45

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AMVUTTRA

Products Affected

- Amvuttra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For polyneuropathy of hereditary transthyretin-mediated amyloidosis, initial therapy: patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease. For polyneuropathy of hereditary transthyretin-mediated amyloidosis, continuation of therapy: patient demonstrates a beneficial response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML
- Apomorphine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of "off" episodes in Parkinson's disease, continuation: The patient is experiencing improvement on the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARANESP AET

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Anemia in patients with myelodysplastic syndrome (MDS).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses: Patient has experienced an inadequate response to or has an intolerance or a contraindication to Procrit (erythropoietin injection). Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for anemia due to chronic kidney disease (CKD): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses: pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL, AND 3) for anemia in patients with myelodysplastic syndrome (MDS): pretreatment serum erythropoietin (EPO) level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses: 1) Patient has received at least 12 weeks of erythropoietin therapy, AND 2) Patient responded to erythropoietin therapy, AND 3) Current Hgb is less than 12 g/dL, AND 4) for CKD: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 weeks

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

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	N/A
Required Medical Information	For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance, or contraindication to maximum tolerated doses of an NSAID and colchicine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARESTIN AET

Products Affected

- Arestin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate response, intolerance, or has a contraindication to treatment with systemic, oral, low-dose doxycycline (i.e., doxycycline 20 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARMODAFINIL

Products Affected

- Armodafinil
- Nuvigil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARZERRA

Products Affected

- Arzerra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Waldenstrom macroglobulinemia (WM), lymphoplasmacytic lymphoma (LPL)
Exclusion Criteria	N/A
Required Medical Information	For WM and LPL: the patient has experienced an intolerance to rituximab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ASPARLAS

Products Affected

- Asparlas

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	21 years of age or younger
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ASPRUZYO

Products Affected

- Aspruzyo Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic angina: 1) The patient has tried ranolazine tablets OR 2) The patient is unable to take ranolazine tablets for any reason (e.g., difficulty swallowing tablets, requires nasogastric administration).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUGTYRO

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is not being prescribed for treatment of iron deficiency anemia in adult patients with chronic kidney disease not on dialysis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUSTEDO

Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tourette's syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUVELITY

Products Affected

- Auvelity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

AVONEX AET

Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AVSOLA

Products Affected

- Avsola

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) Pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis. For FDA-approved indications and off-label uses that overlap: The patient had an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
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AVYCAZ

Products Affected

- Avycaz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	3 months
Other Criteria	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for unresectable, recurrent, or metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.
Exclusion Criteria	N/A
Required Medical Information	For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842A mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including PDGFRA D842V mutations, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in unresectable, recurrent, or metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BAFIERTAM AET

Products Affected

- Bafiertam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) or fibroblast growth factor receptor 2 (FGFR2) genetic alterations AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) recurrent primary carcinoma of the urethra, c) stage II-IV urothelial carcinoma of the bladder, d) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, or e) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BANZEL

Products Affected

- Banzel

- Rufinamide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BAVENCIO

Products Affected

- Bavencio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gestational trophoblastic neoplasia, endometrial carcinoma
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma, the requested drug will be used as either of the following: 1) maintenance therapy if there is no progression on first-line platinum-containing chemotherapy OR 2) subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder, c) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, d) recurrent primary carcinoma of the urethra, or e) urothelial carcinoma of the bladder with stage II-IV disease. For renal cell carcinoma: the disease is advanced, relapsed, or stage IV, AND the requested drug will be used in combination with axitinib as first-line therapy. For gestational trophoblastic neoplasia, the requested drug will be used for multiagent chemotherapy resistant disease when the patient meets either of the following: 1) high risk disease OR 2) has recurrent or progressive intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor). For Merkel cell carcinoma, the requested drug is used for metastatic disease. For endometrial carcinoma, 1) the requested drug will be used as second-line treatment, 2) the disease is recurrent or metastatic, AND 3) the disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BAXDELA

Products Affected

- Baxdela

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	14 days
Other Criteria	N/A

BELBUCA

Products Affected

- Belbuca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adult T-cell leukemia/lymphoma, extranodal NK/T-cell lymphoma, hepatosplenic T-cell lymphoma, breast implant associated anaplastic large cell lymphoma (ALCL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	For patients new to therapy: severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid, antimalarial, or NSAIDs) for SLE, OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE. For lupus nephritis: 1) patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) for lupus nephritis OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BENZNIDAZOLE

Products Affected

- Benznidazole

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patient who has taken disulfiram within the last two weeks.
Required Medical Information	Chagas disease: patient has serologic evidence of Trypanosoma cruzi infection.
Age Restrictions	2 to 12 years of age
Prescriber Restrictions	N/A
Coverage Duration	2 months
Other Criteria	N/A

BEOVU

Products Affected

- Beovu SOSY

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	5 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

BESPONSA

Products Affected

- Besponsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For B-cell precursor acute lymphoblastic leukemia (ALL): The tumor is CD22-positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BEXAROTENE

Products Affected

- Bexarotene CAPS

- Targretin CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS), CD30-positive primary cutaneous anaplastic large cell lymphoma (ALCL), CD30-positive lymphomatoid papulosis (LyP)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BIMZELX

Products Affected

- Bimzelx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BLENREP

Products Affected

- Blenrep

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For relapsed, refractory, or progressive multiple myeloma: Patient must have been treated with at least four prior therapies, including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immunomodulatory agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BLINCYTO

Products Affected

- Blincyto

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of CD19-positive B-cell precursor acute lymphoblastic leukemia (ALL), one of the following criteria are met: 1) the requested drug is used as consolidation or maintenance therapy OR 2) the requested drug is used for relapsed or refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

BOSENTAN

Products Affected

- Bosentan
- Tracleer

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) patient has experienced resistance or intolerance to imatinib or dasatinib. For B-ALL including patient who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Excessive salivation secondary to advanced Parkinson's disease, hemifacial spasm, chronic anal fissure, achalasia, spasmodic dysphonia (laryngeal dystonia), oromandibular dystonia, palmar hyperhidrosis, essential tremor, myofascial pain.
Exclusion Criteria	Cosmetic use.
Required Medical Information	For chronic migraine prophylaxis, initial treatment: patient experiences at least 15 headache days per month, and patient had an inadequate response, intolerance, or a contraindication to a calcitonin gene-related peptide (CGRP) inhibitor. For chronic migraine prophylaxis, continuation of treatment (after 2 injection cycles): More headache-free days per month since starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Chronic migraine, initial tx: 6 months, renewal: Plan Year. Plan Year for all other indications.
Other Criteria	N/A

BRAFTOVI

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used for either of the following: a) subsequent therapy for advanced or metastatic disease, b) primary treatment for unresectable metachronous metastases. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BRISDELLE

Products Affected

- Paroxetine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BRIUMVI AET

Products Affected

- Briumvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including relapsing-remitting disease, active secondary progressive disease, and clinically isolated syndrome]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

BRIVIACT

Products Affected

- Briviact ORAL SOLN
- Briviact TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BRIVIACT INJ

Products Affected

- Briviact INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).
Age Restrictions	1 month of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BRIXADI

Products Affected

- Brixadi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prescribed only for the treatment of pain
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BROMSITE AET

Products Affected

- Bromfenac Sodium SOLN 0.075%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of postoperative inflammation and prevention of ocular pain in a patient undergoing cataract surgery: patient has experienced an intolerable adverse event to brand Bromsite caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

BRONCHITOL

Products Affected

- Bronchitol

- Bronchitol Tolerance Test

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BROVANA AET

Products Affected

- Arformoterol Tartrate
- Brovana

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following: Breo Ellipta (fluticasone/vilanterol), fluticasone/salmeterol, Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone/umeclidinium/vilanterol), Wixela.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BUPRENORPHINE

Products Affected

- Buprenorphine Hcl SUBL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for the treatment of opioid use disorder AND patient meets one of the following: 1) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 2) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 3) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BUPRENORPHINE PATCH

Products Affected

- Buprenorphine PTWK

- Butrans

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BUTALBITAL AET

Products Affected

- Allzital
- Ascomp/codeine
- Bupap TABS 300MG; 50MG
- Butalbital/acetaminophen CAPS
- Butalbital/acetaminophen TABS 300MG; 50MG, 325MG; 50MG
- Butalbital/acetaminophen/caffeine CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine CAPS
- Butalbital/aspirin/caffeine/codeine
- Esgic
- Fioricet CAPS
- Fioricet/codeine CAPS 300MG; 50MG; 40MG; 30MG
- Tencon TABS 325MG; 50MG
- Zebutal CAPS 325MG; 50MG; 40MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The prescriber must acknowledge the benefit of therapy with the requested drug outweighs the potential risks for the patient (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) the patient has experienced an inadequate treatment response or intolerance to a nonsteroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication to NSAIDs.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

BYDUREON

Products Affected

- Bydureon Bcise

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

BYETTA

Products Affected

- Byetta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

BYLVAY

Products Affected

- Bylvay

- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of pruritis in progressive familial intrahepatic cholestasis (PFIC) (initial requests): 1) diagnosis of PFIC has been confirmed by genetic testing, 2) the patient does not have PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3), 3) the patient does not have any other concomitant liver disease, AND 4) the patient has not received a liver transplant. For treatment of pruritis in PFIC (continuation requests): the patient has experienced benefit from therapy (for example, improvement in pruritis). For treatment of cholestatic pruritus with Alagille Syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	For PFIC: 3 months of age or older, For ALGS: 12 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

BYOOVIZ

Products Affected

- Byooviz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CABLIVI

Products Affected

- Cablivi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acquired thrombotic thrombocytopenic purpura (aTTP): Initial course and treatment extension: Patient has not experienced more than 2 recurrences of aTTP while on the requested drug. For aTTP initial course: 1) the request is for treatment during the plasma exchange period and/or directly following the completion of plasma exchange (PE), 2) patient will receive or has received the requested drug with PE, 3) the requested drug will be given in combination with immunosuppressive therapy, and 4) patient will not receive the requested drug beyond 30 days from the cessation of PE unless the patient has documented persistent aTTP. For aTTP extension of therapy: 1) the request is for extension of therapy after the initial course of the requested drug (initial course: treatment with the requested drug during and 30 days after plasma exchange), 2) patient has documented signs of persistent underlying aTTP (example: severely reduced ADAMTS13 activity levels [less than 10%]), 3) the requested drug will be given in combination with immunosuppressive therapy, and 4) patient has not received a prior 28 day extension of therapy after the initial course of the requested drug for this course of treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial course: 60 days, Extension: 28 days
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma
Exclusion Criteria	N/A
Required Medical Information	<p>For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent treatment. For gastrointestinal stromal tumor (GIST): The patient meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed a FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib) OR 2) the requested drug will be used for palliation of symptoms if previously tolerated and effective. For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, Hurthle cell): 1) The disease is locally advanced or metastatic disease, 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI. For endometrial carcinoma: 1) the disease is recurrent or metastatic AND 2) the requested drug will be used as subsequent therapy.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CALCIPOTRIENE

Products Affected

- Calcipotriene CREA
- Calcipotriene FOAM
- Calcipotriene OINT
- Calcipotriene SOLN
- Calcipotriene/betamethasone Dipropionate
- Calcitrene
- Calcitriol OINT
- Enstilar
- Sorilux
- Taclonex SUSP
- Vectical

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Treatment of Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	N/A
Required Medical Information	For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAMBIA

Products Affected

- Cambia

- Diclofenac Potassium PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to diclofenac or any components of the requested drug. History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). The requested drug will be used in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to at least ONE of the following non-steroidal anti-inflammatory drugs (NSAIDs): a) ibuprofen, b) flurbiprofen, c) ketoprofen, d) naproxen AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAMZYOS

Products Affected

- Camzyos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For obstructive hypertrophic cardiomyopathy: 1) before initiating therapy, patient has left ventricular ejection fraction (LVEF) of 55 percent or greater AND 2) patient has New York Heart Association (NYHA) class II-III symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CARAC

Products Affected

- Carac

- Fluorouracil CREA 0.5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who are pregnant or may become pregnant. Patients with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	If being used as part of a compounded product, all active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

CARBAGLU

Products Affected

- Carbaglu

- Carglumic Acid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CEQUA

Products Affected

- Cequa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to Restasis (cyclosporine 0.05 percent emulsion) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Type 2 Gaucher disease, Type 3 Gaucher disease.
Exclusion Criteria	N/A
Required Medical Information	For Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CHANTIX AET

Products Affected

- Varenicline Starting Month Box
- Varenicline Tartrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	This Prior Authorization requirement applies after the patient has received a cumulative 24 weeks of therapy in a Plan Year.

CHENODAL AET

Products Affected

- Chenodal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Contraindicated in the presence of known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis, a gallbladder confirmed as nonvisualizing after two consecutive single doses of dye, radiopaque stones, or gallstone complications or compelling reasons for gallbladder surgery including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary gastrointestinal fistula. Contraindicated in women who are or may become pregnant.
Required Medical Information	For radiolucent stones in a well-opacifying gallbladder, the patient must meet all of the following: 1) the patient has an increased surgical risk due to systemic disease or age, and 2) the patient must have tried and failed, or has a contraindication or intolerance to ursodiol, and 3) cumulative use with the requested drug will not exceed 24 months, and 4) documentation of start date of therapy is provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CHLORDIAZEPOXIDE - 65

Products Affected

- Chlordiazepoxide Hcl CAPS 10MG, 5MG
- Chlordiazepoxide Hydrochloride CAPS 25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: the prescriber must acknowledge the benefit of therapy with the prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) the requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), or b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-preop apprehens and anx-1 mo, Anxiety Disorder-4 mo, Alc Withdrawal-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For bile acid synthesis disorders due to single enzyme defects (SEDs) and adjunctive treatment of peroxisomal disorders (PDs): Diagnosis was confirmed by mass spectrometry or other biochemical or genetic testing. For bile acid synthesis disorders due to SEDs and adjunctive treatment of PDs, continuation of therapy: Patient has achieved and maintained improvement in liver function.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

CIBINQO

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For atopic dermatitis (AD), continuation of therapy: Patient achieved or maintained positive clinical response.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 4 months, Continuation: Plan Year
Other Criteria	N/A

CIMERLI

Products Affected

- Cimerli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CIMZIA

Products Affected

- Cimzia

- Cimzia Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab) OR 2) the patient is currently pregnant and/or breastfeeding. For moderately to severely active rheumatoid arthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding. For active ankylosing spondylitis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding. For active non-radiographic axial spondyloarthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab) OR 2) the patient is currently pregnant and/or breastfeeding.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	<p>For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient meets either of the following: a) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab) OR b) the patient is currently pregnant and/or breastfeeding. For active psoriatic arthritis (new starts only): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release) OR 2) the patient is currently pregnant and/or breastfeeding.</p>

CINQAIR

Products Affected

- Cinqair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 400 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. Severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) Patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) Patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

CINVANTI

Products Affected

- Cinvanti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CITALOPRAM CAP AET

Products Affected

- Citalopram Hydrobromide CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has had a documented trial of one month each of both of the following (a and b): a) generic citalopram tablets AND b) one of the following: formulary generic antidepressant (other than citalopram tablets), Fetzima (levomilnacipran), or Trintellix (vortioxetine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CLOBAZAM

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CLOMIPRAMINE

Products Affected

- Anafranil
- Clomipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Depression, panic disorder
Exclusion Criteria	N/A
Required Medical Information	For obsessive-compulsive disorder (OCD) and panic disorder: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI). For depression: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CLORAZEPATE

Products Affected

- Clorazepate Dipotassium TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

CLOZAPINE ODT

Products Affected

- Clozapine Odt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COLUMVI

Products Affected

- Columvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COLY-MYCIN

Products Affected

- Colistimethate Sodium INJ
- Coly-mycin M

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being used intravenously (IV) or intramuscularly (IM). Administration will not be via nebulizer (Note: CMS endorsed compendia do not support inhalation/nebulization of colistimethate.). The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	Initial approval: 3 months. Renewal: Plan Year
Other Criteria	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CORTROPHIN

Products Affected

- Cortrophin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the following diagnoses, patient has experienced an inadequate treatment response to a parenteral or an oral glucocorticoid (for ophthalmic diseases only, inadequate response to a trial of a topical ophthalmic glucocorticoid is also acceptable): 1) For rheumatic disorders (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis, acute gouty arthritis): The requested drug must be used as adjunctive treatment, 2) For nephrotic syndrome: the requested drug must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic diseases (e.g., severe erythema multiforme, Stevens-Johnson syndrome, severe psoriasis), 6) Ophthalmic diseases, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Allergic states (e.g., serum sickness, atopic dermatitis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MS exacerbation: 3 wks. Allergic states: 1 month. All other diagnoses: 3 months
Other Criteria	N/A

COSENTYX

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab). For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab). For an adult with active psoriatic arthritis (PsA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	For moderate to severe hidradenitis suppurativa (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf).

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Central nervous system (CNS) cancer (i.e., glioma, glioblastoma, astrocytoma, oligodendroglioma), adjuvant systemic therapy for cutaneous melanoma.
Exclusion Criteria	N/A
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, glioblastoma, astrocytoma, oligodendroglioma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Prophylaxis for premature birth in women with a short cervix
Exclusion Criteria	Prescribed to promote fertility
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CRYSVITA

Products Affected

- Crysvida

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CUTAQUIG

Products Affected

- Cutaquig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CUVITRU

Products Affected

- Cuvitru

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CUVRIOR

Products Affected

- Cuvrior

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYCLOPHOSPHAMIDE ORAL

Products Affected

- Cyclophosphamide CAPS
- Cyclophosphamide TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

CYCLOSET AET

Products Affected

- Cycloset

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients with syncopal migraine. Lactating patients. Postpartum patients.
Required Medical Information	Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to metformin or metformin combination products.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Esophageal adenocarcinoma, recurrent non-small cell lung cancer (NSCLC), appendiceal adenocarcinoma, pleural mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer and appendiceal adenocarcinoma: patient has advanced or metastatic disease. For NSCLC: patient has recurrent, advanced, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYSTARAN

Products Affected

- Cystadrops

- Cystaran

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DALFAMPRIDINE

Products Affected

- Ampyra

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAPAGLIFLOZIN AET

Products Affected

- Dapagliflozin Propanediol

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: patient has experienced an intolerable adverse event to brand Farxiga caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAPAGLIFLOZIN-METFORMIN AET

Products Affected

- Dapagliflozin Propanediol/metformin Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: patient has experienced an intolerable adverse event to brand Xigduo XR caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DARAPRIM

Products Affected

- Daraprim

- Pyrimethamine TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia prophylaxis, cystoisosporiasis treatment and secondary prophylaxis
Exclusion Criteria	N/A
Required Medical Information	For primary toxoplasmosis prophylaxis and Pneumocystis jirovecii pneumonia (PCP) prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) AND 2) The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 3 months. For secondary toxoplasmosis prophylaxis: The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 6 months. For cystoisosporiasis treatment: The patient has experienced an intolerance or has a contraindication to TMP-SMX. For secondary cystoisosporiasis prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to TMP-SMX AND 2) The patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 6 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Congen toxo tx: Plan Yr. Acqu toxo tx, prim toxo ppx, PCP ppx: 3mo. Sec toxo ppx, cysto tx/ppx: 6mo
Other Criteria	N/A

DARZALEX

Products Affected

- Darzalex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed/refractory systemic light chain amyloidosis
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DARZALEX FASPRO

Products Affected

- Darzalex Faspro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Post induction therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory AML as a component of repeating the initial successful induction regimen.
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia: 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy, post-induction therapy, or relapsed or refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAYBUE

Products Affected

- Daybue

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DEFERASIROX

Products Affected

- Deferasirox
- Exjade
- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DEMSEER

Products Affected

- Demser

- Metyrosine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DESVENLAFAXINE

Products Affected

- Desvenlafaxine Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DHE NASAL

Products Affected

- Dihydroergotamine Mesylate NASAL SOLN
- Migranal

- Trudhesa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one triptan 5-HT1 receptor agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DIAZEPAM AET

Products Affected

- Diazepam CONC
- Diazepam INJ 5MG/ML
- Diazepam SOLN 5MG/5ML
- Diazepam TABS
- Diazepam Intensol
- Valium TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

DICLOFENAC 1.5% SOL

Products Affected

- Diclofenac Sodium EXTERNAL SOLN 1.5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DICLOFENAC 2% SOL

Products Affected

- Diclofenac Sodium EXTERNAL SOLN 2%
- Pennsaid SOLN 2%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For osteoarthritis of the knee(s): Patient has experienced an inadequate treatment response or intolerance to diclofenac sodium 1.5% topical solution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DICLOFENAC 3% GEL

Products Affected

- Diclofenac Sodium GEL 3%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

DIMETHYL FUMARATE AET

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient has experienced an intolerance to brand Tecfidera due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

DOJOLVI

Products Affected

- Dojolvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For long-chain fatty acid oxidation disorders (LC-FAOD): At least two of the following diagnostic criteria are met: a) disease-specific elevation of acylcarnitine (e.g., C16 and/or C18:1 for CPT2 deficiency, C16-OH and/or C18 and other acylcarnitines for LCHAD and TFP deficiency, C14:1 and/or other long-chain acylcarnitines for VLCAD deficiency) on a newborn blood spot or in plasma, b) low enzyme activity in cultured fibroblasts, c) one or more known pathogenic mutations (e.g., CPT1A, SLC25A20, CPT2, ACADVL, HADHA, HADHB). For LC-FAOD, continuation of therapy: Patient is experiencing benefit from therapy (e.g., improvement in muscle symptoms and/or exercise tolerance).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DOPTELET

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). 2) For continuation of therapy, platelet count response to the requested drug: a) Current platelet count is less than or equal to 200,000/mcL OR b) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year
Other Criteria	N/A

DRIZALMA

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cancer pain, chemotherapy-induced neuropathic pain
Exclusion Criteria	N/A
Required Medical Information	1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration).
Age Restrictions	Generalized Anxiety Disorder - 7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DRONABINOL

Products Affected

- Dronabinol
- Marinol
- Syndros

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nausea and vomiting associated with cancer chemotherapy: The patient has experienced an inadequate treatment response, intolerance, or contraindication to one oral 5-HT ₃ receptor antagonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

DUEXIS

Products Affected

- Duexis

- Ibuprofen/famotidine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to two different regimens containing any combination of a nonsteroidal anti-inflammatory drug (NSAID) and an acid blocker from any of the following drug classes: H2-receptor antagonist (H2RA), proton pump inhibitor (PPI).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DUOBRII

Products Affected

- Duobrii

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis: the patient experienced an inadequate treatment response or intolerance to a topical corticosteroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, AND 2) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: Patient achieved or maintained positive clinical response. For oral corticosteroid dependent asthma, initial therapy: Patient has inadequate asthma control despite current treatment with both of the following medications: 1) High-dose inhaled corticosteroid AND 2) Additional controller (i.e., long acting beta2-agonist, long-acting, muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, initial therapy: Patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: 1) Medium-to-high-dose inhaled corticosteroid, AND 2) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Patient has experienced an inadequate treatment response to Xhance (fluticasone).
Age Restrictions	Atopic Dermatitis: 6 months of age or older, Asthma: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 1 year of age or older

Prescriber Restrictions	N/A
Coverage Duration	AD, initial: 4 months, PN, initial: 6 months, All others: Plan Year
Other Criteria	For eosinophilic esophagitis (EoE), initial therapy: 1) Diagnosis has been confirmed by esophageal biopsy, AND 2) Patient weighs at least 15 kilograms, AND 3) Patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid (e.g., fluticasone propionate or budesonide). For EoE, continuation of therapy: Patient achieved or maintained a positive clinical response. For prurigo nodularis (PN), initial therapy: Patient has had an inadequate treatment response to a topical corticosteroid OR topical corticosteroids are not advisable for the patient. For PN, continuation of therapy: Patient achieved or maintained a positive clinical response.

DURYSTA

Products Affected

- Durysta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DUVYZAT

Products Affected

- Duvyzat

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of Duchenne muscular dystrophy (DMD): The diagnosis was confirmed by genetic testing identifying a disease-causing mutation of the DMD gene.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DYCLOPRO

Products Affected

- Dyclopro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

DYSPORT

Products Affected

- Dysport

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Blepharospasm.
Exclusion Criteria	Cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EGRIFTA

Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use for weight loss
Required Medical Information	For human immunodeficiency virus (HIV)-infected patients with lipodystrophy: Patient is receiving anti-retroviral therapy. For patients who have received at least 6 months of the requested drug: Patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference measurement or computed tomography (CT) scan.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or endocrinologist
Coverage Duration	6 months
Other Criteria	N/A

ELAPRASE

Products Affected

- Elaprase

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mucopolysaccharidosis II (MPS II): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase (IDS) enzyme activity or by genetic testing.
Age Restrictions	16 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ELELYSO

Products Affected

- Elelyso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For type 1 Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ELFABRIO

Products Affected

- Elfabrio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient meets ANY of the following: 1) Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing OR 2) The patient is a symptomatic obligate carrier.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ELIGARD

Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent androgen receptor positive salivary gland tumors
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ELREXFIO

Products Affected

- Elrex fio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ELYXYB

Products Affected

- Elyxyb

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Known hypersensitivity (e.g., anaphylactic reactions and serious skin reactions) to celecoxib or any components of the requested drug. History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). Allergic-type reactions to sulfonamides. The requested drug will be used in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to at least ONE of the following non-steroidal anti-inflammatory drugs (NSAIDs): a) ibuprofen, b) flurbiprofen, c) ketoprofen, d) naproxen AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least ONE triptan 5-HT ₁ agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EMFLAZA

Products Affected

- Deflazacort

- Emflaza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Duchenne muscular dystrophy (DMD): 1) The diagnosis of Duchenne muscular dystrophy (DMD) was confirmed by genetic testing identifying a disease-causing mutation of the DMD gene AND 2) The patient has tried prednisone and experienced unmanageable and clinically significant weight gain/obesity or psychiatric/behavioral issues such as abnormal behavior, aggression, or irritability.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline. For episodic cluster headache, initial: The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan 5-HT ₁ receptor agonist. For episodic cluster headache, continuation: The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

EMPAVELI

Products Affected

- Empaveli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) the diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by either: a) at least 5% PNH cells or b) at least 51% of GPI-AP deficient polymorphonuclear (PMN) cells AND 2) flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation of therapy): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the patient has demonstrated a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PNH initial: 6 months, PNH continuation: Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Major Depressive Disorder (MDD): 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion OR 2) The patient is unable to swallow oral formulations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENBREL

Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hidradenitis suppurativa, non-radiographic axial spondyloarthritis
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENDARI

Products Affected

- Endari

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	5 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENHERTU

Products Affected

- Enhertu

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), recurrent, locally advanced, or metastatic HER2-positive esophageal adenocarcinoma, recurrent HER2-positive gastric or esophagogastric junction adenocarcinoma, brain metastases in patients with HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

ENJAYMO

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cold agglutinin disease (continuation of therapy): patient achieved or maintained a positive clinical response (e.g., improvement in hemoglobin levels, markers of hemolysis [e.g., bilirubin, haptoglobin, lactate dehydrogenase [LDH], reticulocyte count], and a reduction in blood transfusions).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

ENSPRYNG

Products Affected

- Enspryng

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENTADFI

Products Affected

- Entadfi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For benign prostatic hyperplasia (BPH) in a patient with an enlarged prostate: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to combination therapy with a formulary alpha-blocker and finasteride AND 2) The patient has not already received 26 weeks of treatment with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	26 weeks
Other Criteria	N/A

ENTYVIO

Products Affected

- Entyvio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EOHILIA

Products Affected

- Eohilia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For eosinophilic esophagitis (EoE): 1) Diagnosis has been confirmed by esophageal biopsy characterized by greater than or equal to 15 intraepithelial esophageal eosinophils per high power field, AND 2) The patient is exhibiting clinical manifestations of the disease (for example, dysphagia).
Age Restrictions	11 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, allergist, or immunologist
Coverage Duration	6 months
Other Criteria	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EPKINLY

Products Affected

- Epkinly

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EPO

Products Affected

- Procrit

- Retacrit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 weeks
Other Criteria	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

EPOGEN AET

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Anemia due to myelodysplastic syndromes (MDS), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	Patient must have experienced an inadequate treatment response or intolerance to Procrit (epoetin alfa). Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 weeks

Other Criteria	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
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EPRONTIA

Products Affected

- Eprontia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1)The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	Epilepsy: 2 years of age or older, Migraine: 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EPSOLAY

Products Affected

- Epsolay

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of inflammatory lesions of rosacea: 1) the patient has experienced an inadequate treatment response or intolerance to topical metronidazole or topical azelaic acid 15 percent OR 2) the patient has a contraindication that would prohibit a trial of topical metronidazole and topical azelaic acid 15 percent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERAXIS AET

Products Affected

- Eraxis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For esophageal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole and voriconazole.
Age Restrictions	For candidemia and other forms of Candida infections (intra-abdominal abscess and peritonitis): 1 month of age or older.
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	6 weeks
Other Criteria	N/A

ERBITUX

Products Affected

- Erbitux

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Occult primary head and neck cancer, penile cancer, squamous cell skin cancer, non-small cell lung cancer, appendiceal adenocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer: 1) Tumor is negative (wild-type) for RAS (KRAS and NRAS) mutations, and 2) Patient has not previously experienced clinical failure on panitumumab, and 3) If tumor has a BRAF V600E mutation, the requested drug is used in combination with encorafenib. For squamous cell skin cancer, patient has incompletely resected regional disease or inoperable, recurrent, or metastatic disease. For penile cancer, patient has metastatic disease. For non-small cell lung cancer, patient meets both of the following: 1) Patient has a known sensitizing epidermal growth factor receptor (EGFR) mutation, and 2) The requested drug is used following disease progression on EGFR tyrosine kinase inhibitor therapy (e.g., afatinib, erlotinib, gefitinib). For appendiceal adenocarcinoma: 1) Disease is BRAF V600E mutation positive and 2) The requested drug will be used in combination with encorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERGOTAMINE

Products Affected

- Ergotamine Tartrate/caffeine

- Migergot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT1 agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adult medulloblastoma
Exclusion Criteria	N/A
Required Medical Information	For adult medulloblastoma: patient has received prior systemic therapy AND has tumor(s) with mutations in the sonic hedgehog pathway.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERLOTINIB

Products Affected

- Erlotinib Hydrochloride TABS

- Tarceva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the patient has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet

- Pirfenidone

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EVENTITY AET

Products Affected

- Eventity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who have had a myocardial infarction or stroke within the preceding year.
Required Medical Information	For postmenopausal osteoporosis: 1) patient meets ANY of the following: a) history of fragility fracture, OR b) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability, AND 2) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate, OR patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: teriparatide, Tymlos (abaloparatide), or Prolia (denosumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months lifetime total
Other Criteria	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day.

EVEROLIMUS

Products Affected

- Afinitor
- Afinitor Disperz
- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Everolimus TBSO
- Torpenz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangi leiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma, histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis)
Exclusion Criteria	N/A
Required Medical Information	For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: The disease is recurrent/progressive, unresectable, or metastatic AND the patient failed an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD), symptomatic or relapsed/refractory Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	N/A

EVKEEZA

Products Affected

- Evkeeza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For initiation of therapy (tx) to treat homozygous familial hypercholesterolemia (HoFH), patient (pt) must meet ALL of the following: A) Diagnosis of HoFH confirmed by one of the following: 1) Genetic testing to confirm two mutant alleles at low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus OR 2) History of an untreated low-density lipoprotein-cholesterol (LDL-C) greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL and either of the following: a) Presence of cutaneous or tendinous xanthomas before the age of 10 years, or b) An untreated LDL-C level greater than or equal to 190 mg/dL in both parents, which is consistent with heterozygous familial hypercholesterolemia (HeFH), AND B) If the pt is 7 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a high-intensity statin at a maximally tolerated dose or at the maximum dose approved by the Food and Drug Administration (FDA) unless the pt is statin intolerant or has a contraindication to statin tx, AND C) If the pt is 10 years of age or older prior to initiation of treatment, pt is currently receiving treatment with a PCSK9-directed tx at a maximally tolerated dose or at the maximum dose approved by the FDA unless the pt has experienced an intolerance or has a contraindication to all PCSK9-directed therapies, AND D) Prior to initiation of treatment, pt is/was experiencing an inadequate response to lipid-lowering tx as indicated by a treated LDL-C greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease), AND E) Pt will continue to receive concomitant lipid lowering tx. For renewal of tx to treat HoFH: A) Pt meets all initial criteria, AND B) Has responded to tx as demonstrated by a reduction in LDL-C from baseline, AND C) Is receiving concomitant lipid lowering tx.</p>
Age Restrictions	5 years of age or older

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

EVRYSDI

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For spinal muscular atrophy (SMA) initial therapy, patient meets all of the following: 1) Patient has type 1, type 2, or type 3 SMA, and 2) Patient is not dependent on permanent ventilation. For SMA continuation of therapy, patient meets all of the following: 1) Patient has type 1, type 2, or type 3 SMA, AND 2) Patient has experienced clinically significant functional improvement or maintenance of muscle function.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in spinal muscular atrophy
Coverage Duration	Plan Year
Other Criteria	N/A

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EXONDYS 51

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EXTAVIA AET

Products Affected

- Extavia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

EYLEA

Products Affected

- Eylea

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

EYLEA HD

Products Affected

- Eylea Hd

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

FABHALTA

Products Affected

- Fabhalta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) the diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the patient has demonstrated a positive response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Fabry disease, the patient meets ANY of the following: 1) diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) the patient is a symptomatic obligate carrier.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FANAPT

Products Affected

- Fanapt

- Fanapt Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to brand Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FASENRA

Products Affected

- Fasenra

- Fasenra Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. Severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FENSOLVI

Products Affected

- Fensolvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FENTANYL PATCH

Products Affected

- Fentanyl PT72

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FERRIPROX

Products Affected

- Deferiprone
- Ferriprox
- Ferriprox Twice-a-day

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient's transfusional iron overload is not due to myelodysplastic syndrome or Diamond Blackfan anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FETZIMA

Products Affected

- Fetzima

- Fetzima Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FILGRASTIM

Products Affected

- Nivestym

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplantation
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

FILSPARI

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For reduction of proteinuria in patients with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression: 1) The patient had an inadequate response to therapy with a maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) OR 2) The patient experienced an intolerance or has a contraindication to RAS inhibitors.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FILSUVEZ

Products Affected

- Filsuvez

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will not be administered to wound(s) that are currently healed.
Age Restrictions	6 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or wound care specialist
Coverage Duration	Plan Year
Other Criteria	N/A

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FIRDAPSE

Products Affected

- Firdapse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of seizures
Required Medical Information	N/A
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FIRMAGON

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FLECTOR AET

Products Affected

- Diclofenac Epolamine

- Flector

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). For treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two generic oral nonsteroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

FLEQSUVY

Products Affected

- Baclofen SUSP

- Fleqsuvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient is unable to take oral solid dosage forms for any reason (e.g., difficulty swallowing tablets or capsules, requires administration via feeding tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FLUCYTOSINE

Products Affected

- Ancobon
- Flucytosine CAPS 250MG, 500MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 weeks
Other Criteria	N/A

FLUOROURACIL

Products Affected

- Efudex CREA
- Fluorouracil CREA 5%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who are pregnant or may become pregnant.
Required Medical Information	Applies to new starts only. If being used as part of a compounded product, all active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

FLUTICASONE FUROATE AND VILANTEROL AET

Products Affected

- Fluticasone Furoate/vilanterol Ellipta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of asthma and maintenance treatment of chronic obstructive pulmonary disease (COPD): patient has experienced an intolerance to brand Breo Ellipta due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FLUTICASONE PROPIONATE HFA AET

Products Affected

- Fluticasone Propionate Hfa
- Fluticasone Propionate Diskus

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Eosinophilic esophagitis
Exclusion Criteria	N/A
Required Medical Information	For maintenance treatment of asthma: patient has experienced an intolerance to brand Flovent or Arnuity Ellipta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORM ALT PA METFORMIN

Products Affected

- Metformin Hydrochloride TABS
625MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance, caused by an inactive ingredient, to one other formulary product such as metformin immediate-release.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORM ALT PA TOPICAL

Products Affected

- Bruselix GEL
- Lidotral GEL 3.88%
- Lidotral LIQD
- Lidotral SOLN
- Lidotral + Hydrocortisone CREA
- Mycozyl Hc

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORM ALT PA TOPICAL STEROIDS

Products Affected

- Hydroxym CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance to one other formulary topical steroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORM ALT PA VALSARTAN SOL

Products Affected

- Valsartan SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an intolerance, caused by an inactive ingredient, to one other formulary product such as valsartan tablets, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORM ALT TETRACYCLINE

Products Affected

- Tetracycline Hydrochlorid
- Tetracycline Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerable adverse event to tetracycline capsules caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

- Teriparatide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) history of fragility fracture, OR 2) pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has ONE of the following: 1) history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 24 months, Continuation: Plan Year

Other Criteria	For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
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FOSCAVIR

Products Affected

- Foscarnet Sodium INJ 6000MG/250ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	CMV Retinitis: 1) Patient has had an active lesion within the past 6 months OR 2) Patient has had a CD4 cell count less than 100/millimeters cubed (mm ³) within the past 6 months.
Age Restrictions	N/A
Prescriber Restrictions	CMV Retinitis: Prescribed by or in consultation with an ophthalmologist
Coverage Duration	CMV Retinitis: 6 months, Acyclovir-Resistant Mucocutaneous HSV infection: 1 month
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For advanced renal cell carcinoma: the following criteria must be met: 1) The disease is relapsed or refractory, 2) The requested drug must be used after at least two prior systemic therapies, and 3) The patient has experienced disease progression or an intolerable adverse event with a trial of Cabometyx (cabozantinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FRUZAQLA

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FYARRO

Products Affected

- Fyarro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam.
Age Restrictions	Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short bowel syndrome (SBS) initial therapy: 1) If the request is for an adult patient, the patient has been dependent on parenteral support for at least 12 months OR 2) If the request is for a pediatric patient, the patient is dependent on parenteral support. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist.
Coverage Duration	Plan Year
Other Criteria	N/A

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.
Age Restrictions	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GAZYVA

Products Affected

- Gazyva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Small lymphocytic lymphoma (SLL), gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, splenic marginal zone lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas, Burkitt lymphoma, acquired immune deficiency syndrome (AIDS)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, Castleman disease.
Exclusion Criteria	N/A
Required Medical Information	For all diagnoses: the disease is CD20-positive. For gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma: the requested drug is used in any of the following settings: 1) second-line or subsequent therapy, or 2) maintenance therapy, or 3) a substitute for rituximab in a patient who has experienced an intolerance or rare complication (e.g., mucocutaneous reaction) to rituximab, or 4) first-line therapy (nodal marginal zone lymphoma indication only). For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas, Burkitt lymphoma, acquired immune deficiency syndrome (AIDS)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, and Castleman disease: the patient has experienced an intolerance or rare complication (e.g., mucocutaneous reaction) to rituximab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILENYA

Products Affected

- Fingolimod Hydrochloride
- Gilenya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GIMOTI

Products Affected

- Gimoti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient will not use the requested drug for more than 12 consecutive weeks of therapy AND The patient has experienced an inadequate treatment response or intolerance to oral metoclopramide OR The patient is unable to take oral metoclopramide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GIVLAARI

Products Affected

- Givlaari

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLATIRAMER

Products Affected

- Copaxone INJ 20MG/ML, 40MG/ML
- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLOPERBA

Products Affected

- Gloperba

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Pericarditis with multiple recurrences, Behcet's syndrome
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to Mitigare or generic colchicine tablets or capsules that was not attributed to the active ingredient, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GONADOTROPIN

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Induction of ovulation
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GOPRELTO-NUMBRINO

Products Affected

- Cocaine Hydrochloride
- Goprelto
- Numbrino

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Stem cell transplantation related indications, following chemotherapy for acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), neutropenia in myelodysplastic syndrome (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia, patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

GRASTEK

Products Affected

- Grastek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	N/A
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	N/A

GROWTH HORMONE

Products Affected

- Genotropin

- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist.
Coverage Duration	Plan Year

Other Criteria	<p>Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrilen-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for pt with a body mass index [BMI] 25-30 kg/m² and high pretest probability of GHD [e.g., acquired structural abnormalities] or BMI less than 25 kg/m², or d) GST [peak GH level less than or equal to 1 ng/ml] in pt with BMI 25-30 kg/m² and low pretest probability of GHD or BMI greater than 30 kg/m²), OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. Renewal for pediatric GHD, TS, SGA, and adult GHD: Patient is experiencing improvement.</p>
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HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

HALAVEN

Products Affected

- Eribulin Mesylate

- Halaven

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Soft tissue sarcoma (retroperitoneal/intra-abdominal soft tissue sarcoma, pleomorphic rhabdomyosarcoma, extremity/body wall, head/neck), recurrent breast cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

HALOG SOLUTION AET

Products Affected

- Halog SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses: the patient has experienced an inadequate treatment response or intolerance to a generic topical corticosteroid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 Months
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	N/A

HERCEPTIN

Products Affected

- Herceptin INJ 150MG
- Herzuma
- Kanjinti
- Ogivri
- Ontruzant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	N/A
Required Medical Information	All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
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HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

HETLIOZ

Products Affected

- HetlioZ

- Tasimelteon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	Non-24: 18 years of age or older. SMS: 16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist.
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	N/A

HETLIOZ LQ

Products Affected

- HetlioZ Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy.
Age Restrictions	3 to 15 years of age
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year.
Other Criteria	N/A

HIGH RISK MEDICATION - 65

Products Affected

- Anaspaz
- Atropine Sulfate INJ 0.25MG/5ML, 0.4MG/ML, 0.5MG/5ML, 1MG/10ML, 1MG/ML, 8MG/20ML
- Belladonna/opium
- Bentyl INJ
- Chlordiazepoxide/amitriptyline
- Demerol INJ 100MG/ML, 25MG/ML, 50MG/ML, 75MG/ML
- Dicyclomine Hcl SOLN
- Dicyclomine Hydrochloride CAPS
- Dicyclomine Hydrochloride INJ
- Dicyclomine Hydrochloride TABS
- Dihydroergotamine Mesylate INJ
- Diphenhydramine Hcl ELIX
- Dipyridamole TABS
- Disopyramide Phosphate CAPS
- Ergoloid Mesylates TABS
- Guanfacine Hydrochloride
- Guanfacine Hydrochloride Er
- Hyoscyamine Sulfate ELIX
- Hyoscyamine Sulfate SOLN
- Hyoscyamine Sulfate SUBL
- Hyoscyamine Sulfate TABS
- Hyoscyamine Sulfate Odt
- Indocin SUPP
- Indocin SUSP
- Indomethacin CAPS 25MG, 50MG
- Indomethacin SUPP 50MG
- Indomethacin SUSP
- Indomethacin Er
- Intuniv
- Ketorolac Tromethamine TABS
- Levsin TABS
- Levsin/sl
- Meperidine Hcl INJ 100MG/ML, 25MG/ML, 50MG/ML
- Meperidine Hcl ORAL SOLN
- Meperidine Hcl TABS 50MG
- Meprobamate
- Methscopolamine Bromide TABS
- Nifedipine CAPS
- Norpace
- Nulev
- Oscimin SUBL
- Oscimin TABS
- Pentazocine/naloxone Hcl
- Perphenazine/amitriptyline
- Promethazine Vc
- Ryclora
- Thioridazine Hcl TABS 100MG, 10MG, 25MG, 50MG
- Tigan INJ
- Trimethobenzamide Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HIZENTRA

Products Affected

- Hizentra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

HRM - ANTICONVULSANTS - 65

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Epilepsy
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM - HYPNOTICS - 65

Products Affected

- Ambien
- Ambien Cr
- Edluar
- Eszopiclone
- Lunesta
- Zaleplon
- Zolpidem Tartrate SUBL
- Zolpidem Tartrate TABS
- Zolpidem Tartrate Er
- Zolpimist

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For insomnia: 1) The patient meets one of the following: a) the patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) OR b) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND the patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.
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HRM - SCOPOLAMINE - 65

Products Affected

- Scopolamine PT72 1MG/3DAYS
- Transderm-scop PT72 1MG/3DAYS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Excessive salivation
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-ANTIPARKINSON - 65

Products Affected

- Benztropine Mesylate TABS
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine OR 3) The patient has tried the non-HRM alternative drug amantadine AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-CYPROHEPTADINE - 65

Products Affected

- Cyproheptadine Hcl SYRP
- Cyproheptadine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Pruritus, spasticity due to spinal cord injury
Exclusion Criteria	N/A
Required Medical Information	The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-DOXEPIN - 65

Products Affected

- Doxepin Hcl CAPS 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 100MG, 10MG, 150MG, 25MG, 50MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-HYDROXYZINE - 65

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)
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HRM-HYDROXYZINE INJ - 65

Products Affected

- Hydroxyzine Hcl INJ 25MG/ML

- Hydroxyzine Hydrochloride INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam OR 3) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-PROMETHAZINE - 65

Products Affected

- Phenergan INJ
- Promethazine Hcl INJ
- Promethazine Hcl SUPP 12.5MG, 25MG
- Promethazine Hcl TABS 12.5MG
- Promethazine Hydrochloride TABS 25MG, 50MG
- Promethazine Hydrochloride Plain
- Promethegan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRMS - ANTIDEPRESSANTS

Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 100MG, 10MG, 50MG
- Desipramine Hydrochloride
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Norpramin TABS 10MG, 25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neuropathic pain
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRMS - CARBINOXAMINE

Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Ryvent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRMS - CLEMASTINE- 65

Products Affected

- Clemastine Fumarate SYRP
- Clemastine Fumarate TABS 2.68MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRMS - DIABETES AGENTS

Products Affected

- Glyburide TABS 1.25MG, 2.5MG, 5MG
- Glyburide Micronized
- Glyburide/metformin Hydrochloride
- Glynase TABS 1.5MG, 6MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has not tried one of the following non-HRM alternative drugs: glipizide or metformin AND 2) The patient has a contraindication to one of the following non-HRM alternative drugs: glipizide or metformin AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The patient has tried one of the following non-HRM alternative drugs: glipizide or metformin AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: glipizide or metformin AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRMS - TCAS

Products Affected

- Protriptyline Hcl

- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)

HRM-SKELETAL MUSCLE RELAXANTS - 65

Products Affected

- Amrix
- Carisoprodol TABS
- Chlorzoxazone TABS
- Cyclobenzaprine Hydrochloride TABS
- Cyclobenzaprine Hydrochloride Er
- Fexmid
- Lorzone
- Metaxalone
- Methocarbamol INJ 1000MG/10ML
- Methocarbamol TABS
- Norgesic
- Norgesic Forte
- Orphenadrine Citrate INJ
- Orphenadrine Citrate Er
- Orphenadrine/aspirin/caffeine
- Orphengesic Forte
- Robaxin INJ 1000MG/10ML
- Soma
- Tanlor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 2) If the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months

Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.
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HUMIRA

Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter INJ 80MG/0.8ML
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) patient has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) the patient has a contraindication that would prohibit a trial of corticosteroids.

HYFTOR

Products Affected

- Hyftor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HYPERINFLATION NEURO-PSYCH-PAIN

Products Affected

- Diclofenac Potassium CAPS
- Diclofenac Potassium TABS 25MG
- Lofena
- Tramadol Hydrochloride TABS 25MG
- Zipsor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance to one other formulary product.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HYPNOTIC-BENZODIAZEPINES - 65

Products Affected

- Estazolam
- Halcion TABS 0.25MG
- Restoril CAPS 15MG, 22.5MG, 7.5MG
- Temazepam CAPS 15MG, 22.5MG, 7.5MG
- Triazolam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short-term treatment of insomnia: 1) Prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older. Prior authorization applies to greater than cumulative 90 days of therapy per year.

HYQVIA

Products Affected

- Hyqvia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IBSRELA AET

Products Affected

- Ibsrela

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For irritable bowel syndrome with constipation (IBS-C): The patient has had an inadequate treatment response, intolerance, or has a contraindication to Linzess (linaclotide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ICATIBANT

Products Affected

- Firazyr
- Icatibant Acetate
- Sajazir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) patient has accelerated or blast phase CML and no other kinase inhibitor is indicated OR 2) patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib or dasatinib OR 3) patient is positive for the T315I mutation. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IDADICIO

Products Affected

- Adalimumab-aacf (2 Pen)
- Adalimumab-aacf (2 Syringe)
- Idacio (2 Pen)
- Idacio (2 Syringe)
- Idacio Starter Package For Crohns Disease
- Idacio Starter Package For Plaque Psoriasis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For non-infectious intermediate, posterior and panuveitis (new starts only): 1) patient has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) the patient has a contraindication that would prohibit a trial of corticosteroids.

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Newly-diagnosed acute myeloid leukemia
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient is 60 years of age or older with newly-diagnosed AML and meets one of the following: a) patient is not a candidate for intensive induction therapy, or b) patient declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IGALMI

Products Affected

- Igalmi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

ILARIS

Products Affected

- Ilaris INJ 150MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For active systemic juvenile idiopathic arthritis or active adult-onset Still's disease (new starts only), patient must meet either of the following criteria: 1) inadequate response to a nonsteroidal anti-inflammatory drug (NSAID), a corticosteroid, methotrexate, or leflunomide, OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For gout flares, patient must meet all of the following (new starts): 1) two or more gout flares within the previous 12 months prior to the initial treatment with the requested drug, AND 2) inadequate response, intolerance, or contraindication to at least two of the following: non-steroidal anti-inflammatory drugs (NSAIDs), colchicine, or corticosteroids. For gout flares (continuation): patient experienced a positive clinical response from treatment with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ILUMYA

Products Affected

- Ilumya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMATINIB

Products Affected

- Gleevec TABS

- Imatinib Mesylate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, melanoma, Kaposi sarcoma, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFR A fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFR A, or PDGFR B rearrangement in the chronic phase or blast phase
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma: c-Kit mutation is positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, Human Immunodeficiency Virus (HIV) -related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)
Exclusion Criteria	N/A
Required Medical Information	For mantle cell lymphoma: 1) the requested drug will be used as second-line or subsequent therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory, OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma and high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For HIV-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	N/A

IMDELLTRA

Products Affected

- Imdelltra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Unresectable stage II non-small cell lung cancer, metastatic hepatocellular carcinoma
Exclusion Criteria	N/A
Required Medical Information	For unresectable Stage II and III non-small cell lung cancer: The disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy. For biliary tract cancers: Patient has locally advanced, unresectable, recurrent, or metastatic disease. For hepatocellular carcinoma: Patient has unresectable or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMJUDO

Products Affected

- Imjudo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMLYGIC

Products Affected

- Imlygic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For melanoma: The requested drug will be used for the treatment of cutaneous, subcutaneous, or nodal lesions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMPAVIDO

Products Affected

- Impavido

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pregnancy. Sjogren-Larsson-Syndrome.
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

IMVEXXY

Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INBRIJA

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For initial treatment of "off" episodes in Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa, 2) The patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease. For continuation treatment of "off" episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) Pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis. For FDA-approved indications and off-label uses that overlap: The patient had an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
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INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (papillary, Hurthle cell, or follicular), alveolar soft part sarcoma
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INPEFA

Products Affected

- Inpefa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia
Exclusion Criteria	N/A
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INTRAROSA

Products Affected

- Intrarosa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IQIRVO

Products Affected

- Iqirvo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For primary biliary cholangitis (PBC): For initial therapy: 1) Diagnosis of PBC is confirmed by at least two of the following: a) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, b) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (e.g., anti-gp210, anti-sp100), c) Histologic evidence of PBC on liver biopsy (e.g., non-suppurative inflammation and destruction of interlobular and septal bile ducts), AND 2) Patient has an elevated serum ALP level prior to initiation of therapy with the requested drug and meets one of the following requirements: a) Has experienced an inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the patient will continue concomitant therapy with UDCA/ursodiol, b) Is intolerant to prior therapy with UDCA/ursodiol. For PBC (continuation): Patient achieved or maintained a clinical benefit from Iqirvo therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

IR BEFORE ER

Products Affected

- Hydrocodone Bitartrate Er
- Hydromorphone Hcl Er TB24 12MG, 16MG, 8MG
- Hydromorphone Hydrochloride Er TB24 32MG
- Hysingla Er
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Methadone Hydrochloride CONC
- Methadose CONC 10MG/ML
- Methadose Sugar-free
- Morphine Sulfate Er TBCR 100MG, 200MG
- Ms Contin TBCR 100MG, 200MG
- Oxymorphone Hydrochloride Er TB12 10MG, 15MG, 20MG, 30MG, 5MG, 7.5MG
- Oxymorphone Hydrochlorideer
- Xtampza Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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IRESSA

Products Affected

- Gefitinib

- Iressa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For NSCLC: 1) disease must be metastatic, advanced, or recurrent and 2) patient must have a sensitizing EGFR mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ISOTRETINOIN

Products Affected

- Absorica
- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Zenatane

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Refractory acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ISTURISA

Products Affected

- Isturisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

ITRACONAZOLE

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Coccidioidomycosis, Coccidioidomycosis prophylaxis in HIV infection,, Cryptococcosis, Microsporidiosis, Talaromycosis (formerly Penicilliosis), Histoplasmosis prophylaxis in HIV infection, Invasive fungal infection prophylaxis in liver transplant, chronic granulomatous disease (CGD), and hematologic malignancy, Sporotrichosis, Pityriasis versicolor, Tinea versicolor, Tinea corporis, Tinea cruris, Tinea capitis, Tinea manuum, Tinea pedis, primary treatment for allergic bronchopulmonary aspergillosis, primary treatment for chronic cavitary or subacute invasive (necrotizing) pulmonary aspergillosis
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For the treatment of onychomycosis due to dermatophytes (Tinea unguium), the diagnosis has been confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy). For primary treatment of allergic bronchopulmonary aspergillosis, the requested drug is initiated in combination with systemic corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Disseminated/CNS histo, histo/CM/CGD ppx, chronic cavitary/necrotizing PA: 12 mths. Others: 6 mths
Other Criteria	N/A

IVERMECTIN TAB

Products Affected

- Ivermectin TABS

- Stromectol TABS 3MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
Exclusion Criteria	N/A
Required Medical Information	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

IVIG

Products Affected

- Alyglo
- Asceniv
- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 30GM/300ML, 5GM/100ML, 5GM/50ML
- Panzyga
- Privigen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
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IWILFIN

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IXEMPRA

Products Affected

- Ixempra Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IZERVAY

Products Affected

- Izervay

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For geographic atrophy (GA) secondary to age-related macular degeneration (AMD): Patient has not previously received 12 or more months of therapy with the requested drug in each affected eye.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Lower-risk myelofibrosis, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, and myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement
Exclusion Criteria	N/A
Required Medical Information	For polycythemia vera: patient had an inadequate response or intolerance to interferon therapy or hydroxyurea. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JATENZO

Products Affected

- Jatenzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): The patient meets both of the following: 1) The patient has received prior treatment with one of the following: Imbruvica (ibrutinib), Brukinsa (zanubrutinib), or Calquence (acalabrutinib), AND 2) The patient has received prior treatment with a B-cell lymphoma 2 (BCL-2) inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JEMPERLI

Products Affected

- Jemperli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For solid tumors: the patient has mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JOENJA

Products Affected

- Joenja

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For activated phosphoinositide 3-kinase delta syndrome (APDS): the diagnosis was confirmed by genetic testing demonstrating variant in either PIK3CD or PIK3R1.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JUBLIA AET

Products Affected

- Jublia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an adequate trial of one systemic (oral) antifungal alternative such as terbinafine AND 2) Diagnosis of onychomycosis of the toenails due to Trichophyton rubrum or Trichophyton mentagrophytes has been confirmed by a positive fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture or nail biopsy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks
Other Criteria	N/A

JUXTAPID

Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For initiation of therapy to treat homozygous familial hypercholesterolemia (HoFH), patient (pt) must meet ALL of the following: A) Diagnosis of HoFH confirmed by one of the following: 1) Genetic testing to confirm two mutant alleles at low-density lipoprotein receptor (LDLR), apolipoprotein B (ApoB), proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus OR 2) History of an untreated low-density lipoprotein-cholesterol (LDL-C) of greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL and either of the following: a) Presence of cutaneous or tendinous xanthomas before the age of 10 years, or b) An untreated LDL-C level of greater than or equal to 190 mg/dL in both parents, which is consistent with heterozygous familial hypercholesterolemia (HeFH), AND B) Prior to initiation of treatment, the pt is currently receiving treatment with a high-intensity statin at a maximally tolerated dose or at the maximum dose approved by the Food and Drug Administration (FDA) unless the pt is statin intolerant or has a contraindication to statin therapy, AND C) Prior to initiation of treatment with the requested drug, the pt is currently receiving treatment with a PCSK9-directed therapy at a maximally tolerated dose or at the maximum dose approved by the FDA unless the patient has experienced an intolerance or has a contraindication to all PCSK9-directed therapies, AND D) Prior to initiation of treatment, pt is/was experiencing an inadequate response to lipid-lowering therapy as indicated by a treated LDL-C greater than 100 mg/dL (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease), AND E) The pt will continue to receive concomitant lipid lowering therapy. For renewal of therapy to treat HoFH: A) Pt meets all initial criteria, AND B) Has responded to therapy as demonstrated by a reduction in LDL-C from baseline, AND C) Is receiving concomitant lipid lowering therapy.</p>
Age Restrictions	N/A

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

JYNARQUE

Products Affected

- Jynarque

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KALBITOR

Products Affected

- Kalbitor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For lysosomal acid lipase deficiency: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of lysosomal acid lipase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KERYDIN AET

Products Affected

- Tavaborole

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an adequate trial of one systemic (oral) antifungal alternative such as terbinafine AND 2) Diagnosis of onychomycosis of the toenails due to <i>Trichophyton rubrum</i> or <i>Trichophyton mentagrophytes</i> has been confirmed by a positive fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture or nail biopsy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	48 weeks
Other Criteria	N/A

KESIMPTA

Products Affected

- Kesimpta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KETOCONAZOLE

Products Affected

- Ketoconazole TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cushing's syndrome
Exclusion Criteria	Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine.
Required Medical Information	The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

KEVEYIS

Products Affected

- Dichlorophenamide
- Keveyis
- Ormalvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For primary HYPOkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hypokalemic periodic paralysis, OR 3) Patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out. For primary HYPERkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) Patient has a family history of primary hyperkalemic periodic paralysis, OR 3) Patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out. For continuation of therapy for primary HYPOkalemic and primary HYPERkalemic periodic paralysis: Patient is demonstrating a response to therapy with the requested drug as demonstrated by a decrease in the number or severity of attacks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months. Continuation: 12 months
Other Criteria	N/A

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has had an inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For polymyalgia rheumatica (PMR) (new starts only): 1) The patient has experienced an inadequate treatment response to corticosteroids OR 2) The patient has experienced a disease flare while attempting to taper corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KEYTRUDA

Products Affected

- Keytruda INJ 100MG/4ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KIMMTRAK

Products Affected

- Kimmtrak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic juvenile idiopathic arthritis, adult-onset Still's disease, multicentric Castleman's disease, Schnitzler syndrome, and Erdheim-Chester disease.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib-extended release). For active systemic juvenile idiopathic arthritis (new starts only): patient must meet any of the following criteria: 1) Inadequate response to at least one nonsteroidal anti-inflammatory drug (NSAID), corticosteroid, methotrexate or leflunomide, 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Physician global assessment score greater than or equal to 5.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KLISYRI

Products Affected

- Klisyri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KONVOMEP

Products Affected

- Konvomep

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of active benign gastric ulcer: 1) The patient has experienced an inadequate treatment response to a one-month trial each of two proton pump inhibitors (PPIs), OR 2) The patient has experienced an intolerance, or the patient has a contraindication that would prohibit a one-month trial of two proton pump inhibitors (PPIs), AND 3) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive pilocytic astrocytoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For neurofibromatosis type 1: 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KRINTAFEL

Products Affected

- Krintafel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Glucose-6-phosphate dehydrogenase (G6PD) deficiency or unknown G6PD status.
Required Medical Information	The patient is receiving chloroquine-based therapy for acute Plasmodium vivax infection.
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

KRISTALOSE

Products Affected

- Kristalose

- Lactulose PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For constipation: 1) The patient has experienced an inadequate treatment response to a one month trial of generic lactulose solution, OR 2) The patient has experienced an intolerance that would prohibit a one month trial of generic lactulose solution, OR 3) the patient has a contraindication to an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KRYSTEXXA

Products Affected

- Krystexxa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>The requested drug will not be used concomitantly with oral urate-lowering agents. For initiation of therapy for chronic gout: 1) the patient must meet either of the following: a) patient has had an inadequate response to a 3-month trial of a xanthine oxidase inhibitor at the maximum medically appropriate dose unless there is a clinical reason for not completing a trial (e.g., severe allergic reaction, toxicity, intolerance, significant drug interaction, severe renal dysfunction [for allopurinol only], end stage renal impairment [for febuxostat only], or history of CVD or a new CV event [for febuxostat only]), or b) if there is a clinical reason for not completing a 3-month trial with a xanthine oxidase inhibitor, an inadequate response to a 3-month trial of probenecid is required unless there is a clinical reason for not completing a trial of probenecid (e.g., renal insufficiency [glomerular filtration rate of 30 mL per minute or less], severe allergic reaction, toxicity, intolerance, existing blood dyscrasias or uric acid kidney stones, and significant drug interaction) AND 2) the patient experiences frequent gout flares (greater than or equal to 2 per year) OR the patient has at least 1 gout tophus or gouty arthritis. For continuation of therapy for treatment of chronic gout: 1) patient has not had 2 consecutive uric acid levels above 6 mg/dL, AND 2) patient is experiencing benefit from therapy (e.g., serum uric acid levels less than 6 mg/dL, reduction of tophi, reduction of symptoms and/or flares).</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma, relapsed/refractory systemic light chain amyloidosis
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LAGEVRIO AET

Products Affected

- Lagevrio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in a non-hospitalized patient ALL of the following are met: 1) patient is at high risk for progression to severe COVID-19 (e.g., age 60 or older, body mass index [BMI] 30 or greater, hypertension, diabetes mellitus, chronic lung disease), including hospitalization and death, AND 2) treatment with the requested drug is initiated within 5 days of symptom onset.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

LAMPIT

Products Affected

- Lampit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has serologic evidence of Trypanosoma cruzi infection.
Age Restrictions	Less than 18 years of age
Prescriber Restrictions	N/A
Coverage Duration	2 months
Other Criteria	N/A

LAMZEDE

Products Affected

- Lamzede

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For non-central nervous system manifestations of alpha-mannosidosis: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-mannosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LAPATINIB

Products Affected

- Lapatinib Ditosylate

- Tykerb

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma).
Exclusion Criteria	N/A
Required Medical Information	For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LAZCLUZE

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LEDIPASVIR-SOFOSBUVIR AET

Products Affected

- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. The patient must have a contraindication or has experienced an intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) AND the criteria will be applied consistent with current AASLD/IDSA guidance. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	N/A

LEMTRADA AET

Products Affected

- Lemtrada

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including relapsing-remitting disease and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma
Exclusion Criteria	N/A
Required Medical Information	For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma, the disease is advanced, relapsed, or stage IV. For endometrial carcinoma, the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy, AND 4) The patient is not a candidate for curative surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LEQVIO

Products Affected

- Leqvio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Prophylaxis of chemotherapy-induced febrile neutropenia (FN), neutropenia in myelodysplastic syndromes (MDS), neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, severe chronic neutropenia (congenital, cyclic, or idiopathic).
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis of chemotherapy-induced febrile neutropenia (FN), the patient must meet both of the following: 1) Patient has a non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

LEUPROLIDE

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty.
Exclusion Criteria	N/A
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LIBERVANT

Products Affected

- Libervant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 to 5 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LIBRAX

Products Affected

- Chlordiazepoxide Hydrochloride/clidinium Bromide

- Librax

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	If the patient is 65 years of age or older, the prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer
Exclusion Criteria	N/A
Required Medical Information	For cutaneous squamous cell carcinoma: the patient is not a candidate for curative surgery or curative radiation. For basal cell carcinoma: the patient was previously treated with a hedgehog pathway inhibitor OR treatment with a hedgehog pathway inhibitor is not appropriate. For non-small cell lung cancer (NSCLC): 1) the disease is advanced, recurrent, or metastatic AND 2) the tumor does not have an epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or proto-oncogene tyrosine-protein kinase ROS (ROS1) aberration.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LICART AET

Products Affected

- Licart

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). For treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two generic oral nonsteroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

LIDOCAINE PATCHES

Products Affected

- Lidocaine PTCH 5%
- Lidocan
- Lidoderm
- Lidotral 1
- Tridacaine
- Tridacaine II

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LIDOTRAL HC

Products Affected

- Lidotral/hydrocortisone W/peptides & Arnica

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an intolerance to one of the following formulary products: lidocaine ointment 5%, hydrocortisone cream 1% OR 2) Use of the drug is associated with radiation treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LINEZOLID

Products Affected

- Linezolid

- Zyvox

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns. The patient will be using the requested drug orally or intravenously.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed or directed by an Infectious Disease specialist when being converted from intravenous (IV) linezolid (Zyvox)
Coverage Duration	28 days
Other Criteria	N/A

LIQREV

Products Affected

- Liqrev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LITFULO

Products Affected

- Litfulo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For severe alopecia areata (initial): 1) Patient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) AND 2) Patient does not have primarily diffuse pattern alopecia (characterized by diffuse hair shedding) or other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss). For severe alopecia areata (continuation): Patient has achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LIVMARLI

Products Affected

- Livmarli SOLN 9.5MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of cholestatic pruritis in a patient with Alagille syndrome (ALGS) (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis). For treatment of cholestatic pruritis in a patient with Progressive Familial Intrahepatic Cholestasis (PFIC), (initial): 1) diagnosis of PFIC has been confirmed by genetic testing, AND 2) the patient does not have PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein, AND 3) the patient does not have any other concomitant liver disease, AND 4) the patient has not received a liver transplant. For treatment of cholestatic pruritis in a patient with PFIC, (continuation): the patient has experienced benefit from therapy (for example, improvement in pruritis).
Age Restrictions	For ALGS: 3 months of age or older, For PFIC: 12 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

LIVTENCITY

Products Affected

- Livtency

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist.
Coverage Duration	3 months
Other Criteria	N/A

LODOCO

Products Affected

- Lodoco

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): The disease is advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LOQTORZI

Products Affected

- Loqtorzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC). Receptor tyrosine kinase (ROS)-1 rearrangement-positive recurrent, advanced, or metastatic NSCLC following progression on crizotinib, entrectinib, or ceritinib. Symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease. Inflammatory myofibroblastic tumor (IMT) with ALK translocation.
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Patient has ALK-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LOREEV XR

Products Affected

- Loreev Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For anxiety disorder: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety disorder, OR the patient experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), or b) serotonin-norepinephrine reuptake inhibitors (SNRIs) AND 2) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

LUCEMYRA

Products Affected

- Lofexidine Hydrochloride
- Lucemyra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

LUCENTIS

Products Affected

- Lucentis SOSY

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUMRYZ

Products Affected

- Lumryz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. For continuation of therapy: The patient has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

LUNSUMIO

Products Affected

- Lunsumio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUPKYNIS

Products Affected

- Lupkynis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use in combination with cyclophosphamide
Required Medical Information	For lupus nephritis: 1) patient is currently receiving background immunosuppressive therapy (e.g., mycophenolate mofetil, corticosteroids) for lupus nephritis, OR 2) patient has an intolerance or has a contraindication to background immunosuppressive therapy regimen for lupus nephritis. For lupus nephritis continuation: patient is receiving benefit from therapy and the benefit of continuing therapy outweighs the risk of worsening nephrotoxicity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUPRON PED

Products Affected

- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Lupron Depot-ped (6-month)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUPRON-ENDOMETRIOSIS

Products Affected

- Lupron Depot (1-month) INJ 3.75MG
- Lupron Depot (3-month) INJ 11.25MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Breast cancer, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, androgen receptor positive recurrent salivary gland tumor
Exclusion Criteria	N/A
Required Medical Information	For retreatment of endometriosis, the requested drug is used in combination with norethindrone acetate. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	N/A

LUPRON-PROSTATE CA

Products Affected

- Leuprolide Acetate INJ 22.5MG
- Lupron Depot (1-month) INJ 7.5MG
- Lupron Depot (3-month) INJ 22.5MG
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Malignant sex cord-stromal tumors
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to brand Vraylar. For maintenance treatment of bipolar I disorder: the patient experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LYNPARZA

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma.
Exclusion Criteria	N/A
Required Medical Information	For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: 1) The patient has a BRCA mutation and the requested drug will be used in combination with abiraterone and either prednisone or prednisolone OR 2) The patient has progressed on prior treatment with an androgen receptor-directed therapy. For epithelial ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the patient has had at least one prior therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LYRICA CR

Products Affected

- Lyrica Cr
- Pregabalin Er

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LYTGOBI

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extrahepatic cholangiocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For cholangiocarcinoma: 1) patient has a diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma, 2) patient has received a previous treatment, AND 3) patient has a disease that has a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LYVISPAH

Products Affected

- Lyvispah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient is unable to take oral solid dosage forms for any reason (e.g., difficulty swallowing tablets or capsules, requires administration via feeding tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MARGENZA

Products Affected

- Margenza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MAVENCLAD AET

Products Affected

- Mavenclad

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including relapsing-remitting disease and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	N/A

MAYZENT AET

Products Affected

- Mayzent

- Mayzent Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease.
Exclusion Criteria	N/A
Required Medical Information	For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For central nervous system (CNS) cancer (i.e., glioma, oligodendroglioma, astrocytoma, glioblastoma), non-small cell lung cancer, solid tumors, and anaplastic thyroid cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For gallbladder cancer, intrahepatic cholangiocarcinoma, and extrahepatic cholangiocarcinoma: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The disease is unresectable or metastatic, AND 3) The requested drug will be used in combination with dabrafenib. For papillary, follicular, and hurthle cell thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis
Exclusion Criteria	N/A
Required Medical Information	For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MEMANTINE

Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN 2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er
- Namenda TABS 5MG
- Namenda Titration Pak
- Namenda Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This prior authorization only applies to patients less than 30 years of age.

MEPRON AET

Products Affected

- Atovaquone SUSP

- Mepron SUSP

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Babesiosis, Toxoplasmosis, Pneumocystis jirovecii pneumonia prophylaxis in pediatric patients, mild-to-moderate Pneumocystis jirovecii pneumonia treatment in pediatric patients.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of mild-to-moderate Pneumocystis jirovecii pneumonia (PCP): the patient had an intolerance or has a contraindication to sulfamethoxazole/trimethoprim (SMX-TMP). For the prevention of PCP and primary toxoplasmosis prophylaxis indications: A) the patient had an intolerance or has a contraindication to SMX-TMP, AND B) the patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 3 months. For secondary toxoplasmosis prophylaxis: the patient has had a CD4 cell count of less than 200 cells per cubic millimeter within the past 6 months. For babesiosis treatment: the requested drug is used concurrently with azithromycin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary toxoplasmosis prophylaxis: 6 months, All other indications: 3 months
Other Criteria	N/A

MEPSEVII

Products Affected

- Mepsevii

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mucopolysaccharidosis VII (Sly syndrome): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucuronidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

METFORMIN ER

Products Affected

- Glumetza

- Metformin Hydrochloride Er TB24
1000MG, 500MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an intolerance with a 4-week trial of generic Glucophage XR.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

METHYLTESTOSTERONE

Products Affected

- Methitest

- Methyltestosterone CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to alternative testosterone products (e.g., topical testosterone, transdermal testosterone, injectable testosterone). For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MIACALCIN AET

Products Affected

- Calcitonin Salmon INJ

- Miacalcin INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following: generic zoledronic acid, generic pamidronate, generic etidronate, generic cinacalcet, Xgeva (denosumab). For Paget's Disease: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following: generic zoledronic acid, generic alendronate, generic etidronate, generic pamidronate, generic risedronate. For postmenopausal osteoporosis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following: generic zoledronic acid, generic calcitonin spray, generic alendronate, generic risedronate, Forteo (teriparatide), Prolia (denosumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MICO-ZN-PETR OINT

Products Affected

- Miconazole Nitrate/zinc Oxide/white Petrolatum

- Vusion

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The presence of candidal infection has been confirmed by microscopic evaluation (microscopic evidence of pseudohyphae and/or budding yeast) prior to initiating treatment.
Age Restrictions	Pediatric patient 4 weeks of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

MIGLUSTAT

Products Affected

- Miglustat
- Yargesa
- Zavesca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For type 1 Gaucher disease (GD1): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MODAFINIL

Products Affected

- Modafinil TABS
- Provigil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MONJUVI

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	HIV-related B-cell lymphoma, refractory/relapsed/progressive follicular lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For diffuse large B-cell lymphoma (DLBCL) not otherwise specified, HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma, diffuse large B-cell lymphoma (DLBCL) not otherwise specified including DLBCL arising from low grade lymphoma: 1) the patient has relapsed or refractory disease, AND 2) the patient is not eligible for autologous stem cell transplant (ASCT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MOTTEGRITY AET

Products Affected

- Motegrity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, severe inflammatory conditions of the intestinal tract such as Crohn's disease, ulcerative colitis, and toxic megacolon/megarectum.
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or has a contraindication to Amitiza (lubiprostone) and Linzess (linaclotide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MOUNJARO

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

MOZOBIL

Products Affected

- Mozobil

- Plerixafor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

MVASI

Products Affected

- Mvasi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Human immunodeficiency virus (HIV) - related lipodystrophy. Generalized obesity not associated with generalized lipodystrophy.
Required Medical Information	For lipodystrophy patient meets all of the following: 1) Patient has a diagnosis of congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome) OR acquired generalized lipodystrophy (i.e., Lawrence syndrome), 2) Patient has leptin deficiency confirmed by laboratory testing, AND 3) Patient has at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin levels). For lipodystrophy renewal, patient has experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MYCAPSSA

Products Affected

- Mycapssa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MYFEMBREE

Products Affected

- Myfembree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and moderate to severe pain associated with endometriosis in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months, max 24 months total
Other Criteria	N/A

MYLOTARG

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Acute promyelocytic leukemia (APL)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MYOBLOC

Products Affected

- Myobloc

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Primary axillary hyperhidrosis, palmar hyperhidrosis.
Exclusion Criteria	Cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MYTESI AET

Products Affected

- Mytesi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For non-infectious diarrhea in a patient with human immunodeficiency virus/acquired immunodeficiency virus (HIV/AIDS): 1) Patient is receiving anti-retroviral therapy, AND 2) Patient has a history of diarrhea for one month or more characterized by a) persistently loose stools despite regular use of anti-diarrheal medication (ADM) (e.g., loperamide, diphenoxylate, bismuth subsalicylate) or b) one or more watery bowel movements per day without regular ADM use, AND 3) Patient has a negative gastrointestinal (GI) culture or stool test for a) bacteria and b) bacterial toxin and c) ova and parasites and d) viruses, AND 4) Other GI diseases associated with diarrhea (e.g., ulcerative colitis, Crohn's disease, celiac sprue [gluten-enteropathy], chronic pancreatitis, malabsorption) have been ruled out. For continuation of therapy, patient must have experienced symptomatic relief with treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome) was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NAPROXEN-ESOMEPRAZOLE

Products Affected

- Vimovo
- Naproxen/esomeprazole Magnesium

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response or intolerance to two different regimens containing any combination of a nonsteroidal anti-inflammatory drug (NSAID) and an acid blocker from any of the following drug classes: H2-receptor antagonist (H2RA), proton pump inhibitor (PPI).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NEULASTA

Products Affected

- Fulphila
- Fylnetra
- Neulasta
- Neulasta Onpro Kit
- Nyvepria
- Udenyca
- Udenyca Onbody
- Ziextenzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Stem cell transplantation-related indications
Exclusion Criteria	Use of the requested product less than 24 hours before or after chemotherapy.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplantation
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NEXAVAR

Products Affected

- Nexavar

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive AND either of the following is met (1 OR 2): 1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is used in combination with azacitidine or decitabine for low-intensity treatment induction or post-induction therapy AND either a) the patient has is 60 years of age or older or b) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For gastrointestinal stromal tumor (GIST): the patient meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib) OR 2) the requested drug is being used for palliation of symptoms if previously tolerated and effective. For renal cell carcinoma: the disease is advanced. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) the disease has a FLT3 rearrangement AND 2) the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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NEXIUM IV

Products Affected

- Nexium I.v. INJ 40MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For gastroesophageal reflux disease (GERD) with erosive esophagitis (EE): The patient has an intolerance or a contraindication to OR has experienced an inadequate treatment response to a one-month trial of TWO of the following formulary generic proton pump inhibitors (PPIs): lansoprazole, omeprazole, omeprazole/bicarbonate, pantoprazole, esomeprazole sodium, or esomeprazole magnesium.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NEXVIAZYME

Products Affected

- Nexviazyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For late-onset Pompe disease: diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NGENLA AET

Products Affected

- Ngenla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Genotropin. If using target medication for a medically accepted indication not shared by Genotropin, then no trial of Genotropin is required for that target medication. For pediatric growth hormone deficiency (GHD), initial: A) Patient (pt) has pre-treatment (pre-tx) 1-year height (ht) velocity more than 2 standard deviations (SD) below mean OR a pre-tx ht more than 2 SD below mean and a 1-year ht velocity more than 1 SD below mean AND pt meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean OR B) Pt was diagnosed with GHD as a neonate. For pediatric GHD, continuation of therapy: Pt is experiencing improvement.
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NITISINONE

Products Affected

- Nitisinone

- Orfadin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) OR 2) DNA testing (mutation analysis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NITYR

Products Affected

- Nityr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) OR 2) DNA testing (mutation analysis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NOCDURNA AET

Products Affected

- Nocdurna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Hyponatremia or a history of hyponatremia, polydipsia, concomitant use with loop diuretics or systemic or inhaled glucocorticoids, estimated glomerular filtration rate below 50 mL/min/1.73 m ² , syndrome of inappropriate antidiuretic hormone secretion (SIADH), during illnesses that can cause fluid or electrolyte imbalance, heart failure, uncontrolled hypertension.
Required Medical Information	For nocturia due to nocturnal polyuria: 1) the diagnosis has been confirmed with a 24-hour urine collection, AND 2) patient is awakening at least 2 times per night to void. For nocturia due to nocturnal polyuria (continuation therapy): nocturnal polyuria is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months, Renewal: Plan Year
Other Criteria	N/A

NORTHERA

Products Affected

- Droxidopa

- Northera

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For neurogenic orthostatic hypotension (nOH): Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy for nOH, patient must experience a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy for nOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

NOURIANZ AET

Products Affected

- Nourianz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Parkinson's disease (PD) with off episodes: 1) The patient has experienced an inadequate treatment response to a one month trial each of TWO of the following in combination with levodopa/carbidopa: a dopamine agonist (e.g., ropinirole, pramipexole), a catechol-O-methyl transferase (COMT) inhibitor (e.g., entacapone), or a monoamine oxidase B (MAO-B) inhibitor (e.g., rasagiline, selegiline) OR 2) The patient has experienced an intolerance to or has a contraindication that would prohibit a trial of each of the following treatments: a dopamine agonist (e.g., ropinirole, pramipexole), a catechol-O-methyl transferase (COMT) inhibitor (e.g., entacapone), and a monoamine oxidase B (MAO-B) inhibitor (e.g., rasagiline, selegiline).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NOXAFIL POWDER

Products Affected

- Noxafil PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs 40 kilograms or less.
Age Restrictions	2 to less than 18 years of age
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NOXAFIL SUSP

Products Affected

- Noxafil SUSP

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.
Age Restrictions	13 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Oropharyngeal candidiasis: 1 month. All other indications: 6 months
Other Criteria	N/A

NP GROWTH HORMONE

Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Omnitrope
- Saizenprep Reconstitutionkit
- Zomacton

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	<p>The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Genotropin. If using target medication for a medically accepted indication not shared by Genotropin, then no trial of Genotropin is required for that target medication.</p> <p>Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.</p>
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist.

Coverage Duration	Plan Year
Other Criteria	<p>Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrilen-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for pt with a body mass index [BMI] 25-30 kg/m² and high pretest probability of GHD [e.g., acquired structural abnormalities] or BMI less than 25 kg/m², or d) GST [peak GH level less than or equal to 1 ng/ml] in pt with BMI 25-30 kg/m² and low pretest probability of GHD or BMI greater than 30 kg/m²), OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. Renewal for pediatric GHD, TS, SGA, and adult GHD: Patient is experiencing improvement.</p>

NPLATE

Products Affected

- Nplate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For immune thrombocytopenia (ITP) (new starts): 1) Patient has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). For ITP (continuation of therapy): Patient has platelet count response to the requested drug with one of the following: 1) Current platelet count is less than or equal to 200,000/mcL OR 2) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For ITP: Initial: 6 months, Reauthorization: Plan Year For HSARS: Plan Year
Other Criteria	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: Patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis. For hypereosinophilic syndrome (HES), initial therapy: 1) Patient has had HES for greater than or equal to 6 months, 2) Patient has HES without an identifiable non-hematologic secondary cause, 3) Patient does not have FIP1L1-PDGFRα kinase-positive HES, 4) Patient has a history or presence of a blood eosinophil count of at least 1000 cells per microliter, AND 5) Patient has been on a stable dose of at least one HES therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy). For HES, continuation of therapy: Patient has a beneficial response to treatment as demonstrated by a reduction in HES flares.</p>
Age Restrictions	Asthma: 6 years of age or older, EGPA and CRSwNP: 18 years of age or older, HES: 12 years of age or older

Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) The patient has experienced inadequate treatment response to Xhance (fluticasone).

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NULIBRY

Products Affected

- Nulibry

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For molybdenum cofactor deficiency (MoCD) Type A: 1) Diagnosis of MoCD Type A is confirmed by genetic testing OR 2) Patient has a presumed diagnosis of MoCD Type A based on clinical presentation and genetic test results are pending.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Presumed Diagnosis: 3 months, Confirmed Diagnosis: Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

NUPLAZID

Products Affected

- Nuplazid CAPS

- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT1 receptor agonist . Preventive treatment of migraine, initial: The patient meets either of the following: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. Preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Preventive treatment of migraine - initial: 3 months, All other indications: Plan Year
Other Criteria	N/A

Ocaliva

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For primary biliary cholangitis (PBC) without cirrhosis or with compensated cirrhosis without evidence of portal hypertension: For initial therapy, 1) Diagnosis of PBC (previously known as primary biliary cirrhosis) is confirmed by at least two of the following: A) Biochemical evidence of cholestasis with elevation of alkaline phosphatase (ALP) level for at least 6 months duration, B) Presence of antimitochondrial antibodies (AMA) (titer greater than 1:40 by immunofluorescence or immunoenzymatic reactivity) or PBC-specific antinuclear antibodies ANA (eg, anti-gp210, anti-sp100), or C) Histologic evidence of PBC on liver biopsy (eg, non-suppurative inflammation and destruction of interlobular and septal bile ducts) and 2) Patient has an elevated serum ALP level prior to initiation of therapy with the requested drug and meets one of the following requirements: A) Inadequate response to at least 12 months of prior therapy with ursodeoxycholic acid (UDCA)/ursodiol and the patient will continue concomitant therapy with UDCA/ursodiol, or B) Intolerance to UDCA/ursodiol. For continuation of therapy for PBC: patient achieved or maintained a clinical benefit from Ocaliva therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Continuation: Plan Year.
Other Criteria	N/A

OCREVUS

Products Affected

- Ocrevus

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OCTREOTIDE

Products Affected

- Octreotide Acetate INJ
1000MCG/ML, 100MCG/ML,
200MCG/ML, 500MCG/ML,
50MCG/ML
- Sandostatin INJ 100MCG/ML,
500MCG/ML, 50MCG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of thymomas and thymic carcinomas.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control of thymomas and thymic carcinomas: The requested drug will be used for any of the following: 1) locally advanced or metastatic disease, 2) postoperatively following tumor resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ODACTRA

Products Affected

- Odactra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	N/A
Age Restrictions	12 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis (new starts only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OGSIVEO

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OJEMDA

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For relapsed or refractory pediatric low-grade glioma (LGG): the patient's tumor is positive for either a) BRAF fusion or rearrangement OR b) BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OJJAARA

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OLUMIANT

Products Affected

- Olumiant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For severe alopecia areata, initial therapy: 1) patient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) AND 2) patient does not have primarily diffuse pattern alopecia (characterized by diffuse hair shedding) or other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss). For severe alopecia areata, continuation of therapy: patient has achieved or maintained a positive clinical response as evidenced by an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OMVOH

Products Affected

- Omvoh

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONCASPAR

Products Affected

- Oncaspar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Extranodal natural killer/T-cell lymphoma, hepatosplenic T-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For extranodal natural killer/T-cell lymphoma, acute lymphoblastic leukemia, and hepatosplenic T-cell lymphoma: the requested drug must be used in conjunction with multi-agent chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONGENTYS AET

Products Affected

- Ongentys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Parkinson's disease (PD) with off episodes: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a one month trial of generic carbidopa/levodopa/entacapone or generic entacapone used in combination with a generic levodopa/carbidopa product.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONIVYDE

Products Affected

- Onivyde

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For pancreatic adenocarcinoma: 1) the requested drug will be used in combination with fluorouracil and leucovorin, OR 2) the requested drug will be used in combination with oxaliplatin, fluorouracil, and leucovorin. For ampullary adenocarcinoma: 1) the requested drug will be used as a subsequent therapy, AND 2) the requested drug will be used in combination with fluorouracil and leucovorin.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	Plan Year
Other Criteria	N/A

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPDIVO

Products Affected

- Opdivo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPDUALAG

Products Affected

- Opdualag

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPFOLDA

Products Affected

- Opfolda

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For late-onset Pompe disease: 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing AND 2) The requested drug will be used in combination with Pombiliti (cipaglucosidase alfa-atga) AND 3) Patient meets BOTH of the following: A) weighs at least 40 kilograms (kg), B) is not improving on their current enzyme replacement therapy (ERT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPSYNVI

Products Affected

- Opsynvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPZELURA

Products Affected

- Opzelura

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis (AD) in a non-immunocompromised patient, initial therapy: 1) The requested drug will be used on sensitive areas (e.g., face, genitals, or skin folds) and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor, OR 2) The requested drug will be used on non-sensitive (or remaining) skin areas and the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor or a medium or higher potency topical corticosteroid. For the topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in a non-immunocompromised patient, continuation of therapy: The patient achieved or maintained positive clinical response. For the topical treatment of nonsegmental vitiligo (NSV): The requested drug will be applied to affected areas of 10 percent or less body surface area (BSA). For the topical treatment of nonsegmental vitiligo, continuation of therapy: The patient achieved or maintained meaningful repigmentation.
Age Restrictions	AD, NSV: 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	AD, Initial: 3 months, NSV, Initial: 7 months, AD, NSV Continuation: Plan Year
Other Criteria	N/A

ORACEA AET

Products Affected

- Doxycycline CPDR
- Oracea

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a formulary generic topical metronidazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORALAIR

Products Affected

- Oralair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	N/A
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	N/A

ORAL-INTRANASAL FENTANYL

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough cancer-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a cancer patient with underlying cancer pain AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the cancer-related diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the cancer-related diagnosis.] AND 3) The patient is currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying cancer pain AND 4) The requested drug is intended only for use in opioid tolerant patients. The patient can safely take the requested dose based on their current opioid use history. [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORENCIA

Products Affected

- Orenzia

- Orenzia Clickject

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For an adult with active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORENITRAM

Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORIAHNN

Products Affected

- Oriahnn

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal patient: the patient has not already received greater than or equal to 24 months of treatment with any elagolix-containing drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months, max 24 months total
Other Criteria	N/A

ORILISSA

Products Affected

- Orilissa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe pain associated with endometriosis: the patient has not already received greater than or equal to 24 months of treatment with any elagolix-containing drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months, max 24 months total
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORLADEYO

Products Affected

- Orladeyo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

ORSERDU

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: 1) the disease is estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2)-negative, and ESR1 mutated AND 2) the patient meets either of the following: a) the disease is advanced, recurrent, or metastatic AND the patient has disease progression following at least one line of endocrine therapy OR b) the disease had no response to preoperative systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OSPHERA

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OXANDROLONE

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cachexia associated with AIDS (HIV wasting). To enhance growth in patients with Turners Syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Turners Syndrome: Plan Year, All other diagnoses: 6 months
Other Criteria	Coverage will be denied if request is for an indication excluded from Medicare Part D.

OXAZEPAM - 65

Products Affected

- Oxazepam

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders, anxiety associated with depression, and the management of anxiety, tension, agitation and irritability in older patients: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, Alcohol Withdrawal-Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

OXBRYTA

Products Affected

- Oxbryta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	4 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	8 weeks
Other Criteria	N/A

OXLUMO

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For primary hyperoxaluria type 1 (PH1): diagnosis has been confirmed by a molecular genetic test showing a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. For continuation of therapy: the patient has experienced decreased or normalized levels of either of the following since initiating therapy: 1) urinary oxalate, 2) plasma oxalate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OXYCONTIN AET

Products Affected

- Oxycodone Hcl Er T12A
- Oxycodone Hydrochloride Er T12A 10MG, 20MG
- Oxycontin T12A

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term opioid treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid for at least 30 days OR the patient has severe, continuous pain and the patient has taken an immediate-release opioid for at least one week AND 5) For chronic pain except pain associated with cancer, sickle cell disease, a terminal condition, or palliative care: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two alternative formulary long-acting opioids such as Hysingla ER, controlled-release morphine, fentanyl patches.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OZEMPIC

Products Affected

- Ozempic

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulintropic polypeptide [GIP] and GLP-1 RAs).

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma, the requested drug will be used for treatment of any of the following: a) locally advanced or metastatic urothelial carcinoma, b) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder, c) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, d) recurrent primary carcinoma of the urethra, or e) stage II-IV urothelial carcinoma of the bladder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PALFORZIA

Products Affected

- Palforzia Initial Dose Escalation
- Palforzia Level 1
- Palforzia Level 10
- Palforzia Level 11 (maintenance)
- Palforzia Level 11 (titration)
- Palforzia Level 2
- Palforzia Level 3
- Palforzia Level 4
- Palforzia Level 5
- Palforzia Level 6
- Palforzia Level 7
- Palforzia Level 8
- Palforzia Level 9

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Uncontrolled asthma. History of eosinophilic esophagitis. Other eosinophilic gastrointestinal disease.
Required Medical Information	N/A
Age Restrictions	Up-Dosing and Maintenance phase of treatment: 1 year of age or older. Otherwise: 1 to 17 years of age.
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	N/A

PALYNZIQ AET

Products Affected

- Palynziq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For phenylketonuria (PKU): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to sapropterin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PEGASYS

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia.
Exclusion Criteria	N/A
Required Medical Information	For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: 12-48wks. Criteria applied consistent w/current AASLD/IDSA guidance. HBV: 48wks. Other: Plan Yr
Other Criteria	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PERFOROMIST AET

Products Affected

- Formoterol Fumarate NEBU

- Perforomist

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Bevespi Aerosphere (glycopyrrolate/formoterol) AND Serevent Diskus (salmeterol).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), recurrent HER2-positive salivary gland tumors, brain metastases from HER2-positive breast cancer, unresectable or metastatic HER2-positive hepatobiliary cancers (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma).
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type AND 2) the requested drug is used in combination with trastuzumab AND 3) the patient has not had previous treatment with a HER2 inhibitor. For HER2-positive recurrent salivary gland tumors, brain metastases from HER2 positive breast cancer, and unresectable or metastatic HER2-positive hepatobiliary cancer (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma): the requested drug is used in combination with trastuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PHENYL BUTYRATE

Products Affected

- Buphenyl
- Olpruva
- Pheburane
- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PHESGO

Products Affected

- Phesgo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PIASKY

Products Affected

- Piasky

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) The diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) Flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) The patient has demonstrated a positive response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PLEGRIDY AET

Products Affected

- Plegridy

- Plegridy Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorders (B-cell type), acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified, and AIDS-related plasmablastic lymphoma), and follicular lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome.
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma, patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMBILITI

Products Affected

- Pombiliti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For late-onset Pompe disease: 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing AND 2) The requested drug will be used in combination with Opfolda (miglustat) AND 3) Patient meets BOTH of the following: A) weighs at least 40 kilograms (kg), B) is not improving on their current enzyme replacement therapy (ERT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PONVORY AET

Products Affected

- Ponvory

- Ponvory 14-day Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

PORTRAZZA

Products Affected

- Portrazza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POSACONAZOLE

Products Affected

- Noxafil TBEC
- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs greater than 40 kilograms.
Age Restrictions	Treatment of Invasive Aspergillosis: 13 years of age or older, Prophylaxis of Invasive Aspergillus and Candida Infections: 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

POTELIGEO

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Adult T-cell leukemia/lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PREGABALIN

Products Affected

- Lyrica
- Pregabalin CAPS
- Pregabalin SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Cancer-related neuropathic pain, cancer treatment-related neuropathic pain
Exclusion Criteria	N/A
Required Medical Information	For the management of postherpetic neuralgia, the management of neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain, and cancer treatment-related neuropathic pain: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PRETOMANID AET

Products Affected

- Pretomanid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For tuberculosis (TB), patient meets ALL of the following: 1) the requested drug is being used for treatment of pulmonary extensively drug resistant (XDR), treatment intolerant or nonresponsive multidrug resistant (MDR) tuberculosis, AND 2) the requested drug is used in combination with bedaquiline and linezolid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PREVYMIS

Products Affected

- Prevymis TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 months
Other Criteria	N/A

PROAIR DIGIHALER

Products Affected

- Proair Digihaler

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Treatment of bronchospasm associated with chronic obstructive pulmonary disease (COPD) in an adult patient.
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to albuterol HFA.
Age Restrictions	Bronchospasm and exercise-induced bronchospasm: 4 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROCYSBI

Products Affected

- Procysbi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For nephropathic cystinosis: 1) Diagnosis of was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has experienced an intolerance to prior therapy with Cystagon (cysteamine bitartrate immediate-release).
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROLATE AET

Products Affected

- Oxycodone And Acetaminophen
- Oxycodone Hydrochloride/acetaminophen SOLN 300MG/5ML; 10MG/5ML
- Oxycodone/acetaminophen TABS 300MG; 10MG, 300MG; 5MG
- Prolate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate: The patient has experienced an intolerance to two other generic acetaminophen-oxycodone combination products due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) that is due to an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROLENSA AET

Products Affected

- Bromfenac Sodium SOLN 0.07%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of postoperative inflammation and reduction of ocular pain in a patient who has undergone cataract surgery: patient has experienced an intolerable adverse event to brand Prolensa caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient (pt) has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins AND b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma) AND c) For chronic ITP only: pt has had an inadequate response or intolerance to Doptelet (avatrombopag). 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL, OR b) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: pt is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) Pt will use the requested drug with standard immunosuppressive therapy for first line treatment OR b) the pt had an insufficient response to immunosuppressive therapy. 2) For continuation of therapy: 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.</p>
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
Other Criteria	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).

PULMOZYME

Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

PYRUKYND

Products Affected

- Pyrukynd

- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hemolytic anemia in a patient with pyruvate kinase (PK) deficiency: Diagnosis was confirmed by an enzyme assay demonstrating deficiency of PK enzyme activity or by genetic testing. For hemolytic anemia in a patient with PK deficiency (continuation of therapy): Patient achieved or maintained a positive clinical response (e.g., improvement in hemoglobin levels, reduction in blood transfusions).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 7 months, Continuation: Plan Year
Other Criteria	N/A

QBREXZA

Products Affected

- Qbrexza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QELBREE

Products Affected

- Qelbree

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient meets all of the following: 1) the patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD), AND 2) the patient will be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to atomoxetine OR the patient has difficulty swallowing oral capsules.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent/progressive or unresectable gastrointestinal stromal tumor (GIST)
Exclusion Criteria	N/A
Required Medical Information	For unresectable, recurrent/progressive, advanced, or metastatic gastrointestinal stromal tumor (GIST), the patient meets either of the following: 1) patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) patient has experienced disease progression following treatment with avapritinib and dasatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QUETIAPINE XR

Products Affected

- Quetiapine Fumarate Er

- Seroquel Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
Exclusion Criteria	N/A
Required Medical Information	For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls]. For treatment of schizophrenia: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of manic or mixed episodes associated with bipolar I disorder or maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of depressive episodes associated with bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: lurasidone, olanzapine, quetiapine immediate-release. For acute treatment of depressive episodes associated with bipolar II disorder: The patient experienced an inadequate treatment response or intolerance to generic quetiapine immediate-release. For adjunctive treatment of major depressive disorder (MDD): The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine immediate-release.
Age Restrictions	N/A

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

QUININE SULFATE

Products Affected

- Qualaquin

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	N/A
Required Medical Information	For babesiosis: the requested drug is used in combination with clindamycin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

QULIPTA

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants. Preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

QUTENZA

Products Affected

- Qutenza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For postherpetic neuralgia (PHN) and diabetic peripheral neuropathy (DPN) of the feet: The patient has experienced an inadequate treatment response to one month of generic gabapentin or has an intolerance or contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QUVIVIQ

Products Affected

- Quviviq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For insomnia: Potential factors contributing to sleep disturbances (e.g., inappropriate sleep hygiene, sleep environment issues, treatable comorbid medical/psychiatric disorders) have been addressed or are currently being addressed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

QUZYTIR

Products Affected

- Quzyttir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RADICAVA

Products Affected

- Edaravone
- Radicava
- Radicava Ors
- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For amyotrophic lateral sclerosis (ALS): 1) Diagnosis is classified as definite or probable ALS, AND 2) For new starts only: Patient has scores of at least 2 points on all 12 areas of the revised ALS Functional Rating Scale (ALSFRS-R). For continuation of therapy for ALS: There is a clinical benefit from therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RAGWITEK

Products Affected

- Ragwitek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Severe, unstable or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. History of eosinophilic esophagitis.
Required Medical Information	N/A
Age Restrictions	5 to 65 years of age
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	N/A

RAVICTI AET

Products Affected

- Ravicti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urea cycle disorders (UCD): 1) Diagnosis of UCD was confirmed by enzymatic, biochemical or genetic testing AND 2) Patient has experienced an intolerance to sodium phenylbutyrate therapy, OR patient has not tried sodium phenylbutyrate because of a comorbid condition that prohibits a trial due to its sodium content (e.g., heart failure, hypertension, renal impairment, edema).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REBIF OPEN

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient must have tried and failed or has a contraindication or intolerance to two of the following: brand Aubagio, Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone, brand Tecfidera, Vumerity (diroximel fumarate), Zeposia (ozanimod).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

REBLOZYL

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For anemia with beta thalassemia or anemia in myelodysplastic syndromes or myelodysplastic/myeloproliferative neoplasm, patient meets the following: For new starts, the patient has a diagnosis of anemia evidenced by a pretreatment or pretransfusion hemoglobin level less than or equal to 11 grams per deciliter (g/dL). For continuation of therapy, patient meets all of the following: 1) patient has a pre-dose hemoglobin level less than or equal to 11 g/dL (the current or current pretransfusion hemoglobin level must be considered for dosing purposes) or the prescriber agrees to hold the dose until the hemoglobin level falls to or below 11 g/dL, 2) patient must achieve or maintain red blood cell transfusion burden reduction or they have not received three consecutive doses at the maximum dose, and 3) patient must not experience an unacceptable toxicity on the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For beta thalassemia: 16 weeks. For myelodysplastic syndromes: 24 weeks.
Other Criteria	N/A

REBYOTA

Products Affected

- Rebyota

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin or toxigenic C. difficile, AND 2) The requested drug will be administered 24 to 72 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

RECARBRIO

Products Affected

- Recarbrio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A

RECORLEV

Products Affected

- Recorlev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	20 weeks
Other Criteria	N/A

RELEUKO

Products Affected

- Releuko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hematopoietic syndrome of acute radiation syndrome, mobilization of peripheral blood progenitor cells (PBPCs), neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplantation
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN), patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

RELISTOR INJ

Products Affected

- Relistor INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation: 1) the patient is unable to tolerate oral medications OR 2) the patient meets one of the following criteria A) experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik) OR B) the patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	N/A

RELISTOR TAB

Products Affected

- Relistor TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	N/A

RELTONE

Products Affected

- Reltone

- Ursodiol CAPS 200MG, 400MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For a patient with radiolucent, noncalcified gallbladder stones less than 20 millimeters in greatest diameter in whom elective cholecystectomy would be undertaken except for the presence of increased surgical risk due to systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery: the dosage cannot be accommodated with generic ursodiol 300 milligram (mg) capsules. For the prevention of gallstone formation in an obese patient experiencing rapid weight loss: the patient has experienced an intolerance to generic ursodiol 300 mg capsules due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RELYVRIO

Products Affected

- Relyvrio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For amyotrophic lateral sclerosis (ALS): 1) Patient has a diagnosis of definite or probable ALS AND 2) For continuation of therapy: There is a clinical benefit from therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REMICADE

Products Affected

- Infliximab

- Remicade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) Pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis. For FDA-approved indications and off-label uses that overlap: The patient had an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
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RENFLEXIS

Products Affected

- Renflexis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Behcet's syndrome, hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Pt meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) or leflunomide OR b) intolerance or CI to MTX AND leflunomide, AND 2) pt meets ANY of the following: a) inadequate response, intolerance or CI to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Pt meets ANY of the following: a) pt has experienced inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with MTX, cyclosporine, or acitretin, OR b) pharmacologic treatment with MTX, cyclosporine, or acitretin is contraindicated, OR c) pt has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): Inadequate response or intolerance or has a CI to a trial of immunosuppressive therapy for uveitis.
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REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer, Langerhans Cell Histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, RET-fusion positive recurrent or persistent thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), RET-fusion positive anaplastic thyroid carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
Age Restrictions	Medullary thyroid cancer and thyroid cancer: 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REVLIMID

Products Affected

- Lenalidomide

- Revlimid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castleman's disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REYVOW

Products Affected

- Reyvow

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute migraine: 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT ₁ receptor agonist AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to Nurtec ODT (rimegepant) or Ubrelvy (ubrogepant).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REZDIFFRA

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For noncirrhotic nonalcoholic steatohepatitis (NASH) (initial): patient has moderate to advanced liver fibrosis (consistent with Stages F2 to F3) at baseline, which was confirmed by liver biopsy or magnetic resonance elastography (MRE). For NASH (continuation): The patient demonstrates a beneficial response to therapy (for example, improvement in liver function such as reduction in alanine aminotransferase (ALT), reduction of liver fat content by imaging such as magnetic resonance imaging-protein density fat fraction (MRI-PDFF) or FibroScan controlled attenuation parameter (CAP)).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	Plan Year
Other Criteria	N/A

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REZZAYO

Products Affected

- Rezzayo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	6 weeks
Other Criteria	N/A

RIABNI

Products Affected

- Riabni

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	<p>Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation from chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLN, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, Pediatric aggressive mature B-cell lymphomas, Rosai-Dorfman disease, and Pediatric mature B-cell acute leukemia (B-AL).</p>
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.</p>

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For moderately to severely active Crohn's disease (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For atopic dermatitis (new starts only): 1) patient has refractory, moderate to severe disease, AND 2) patient has had an inadequate response to treatment with other systemic drug products, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): the patient achieved or maintained positive clinical response. For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.</p>
Age Restrictions	Atopic dermatitis: 12 years of age or older

Prescriber Restrictions	N/A
Coverage Duration	Atopic dermatitis (initial): 4 months, All others: Plan Year
Other Criteria	For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel (etanercept), Humira [adalimumab], Idacio [adalimumab-aacf]).

RINVOQ LQ

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For moderately to severely active Crohn's disease (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For atopic dermatitis (new starts only): 1) patient has refractory, moderate to severe disease, AND 2) patient has had an inadequate response to treatment with other systemic drug products, including biologics, or use of these therapies are inadvisable. For atopic dermatitis (continuation of therapy): the patient achieved or maintained positive clinical response.</p> <p>For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).</p> <p>For non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.</p>
Age Restrictions	Atopic dermatitis: 12 years of age or older

Prescriber Restrictions	N/A
Coverage Duration	Atopic dermatitis (initial): 4 months, All others: Plan Year
Other Criteria	For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel (etanercept), Humira [adalimumab], Idacio [adalimumab-aacf]).

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	<p>Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation from chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLT, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pediatric aggressive mature B-cell lymphomas, and Rosai-Dorfman disease.</p>
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.</p>

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Castleman disease (CD), high-grade B-cell lymphoma, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, marginal zone lymphomas (nodal marginal zone lymphoma, extranodal marginal zone lymphoma, and splenic marginal zone lymphoma), mantle cell lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), hairy cell leukemia, small lymphocytic lymphoma (SLL), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma.
Exclusion Criteria	N/A
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RIVFLOZA

Products Affected

- Rivfloza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For primary hyperoxaluria type 1 (PH1): diagnosis has been confirmed by a molecular genetic test showing a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene or liver enzyme analysis demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity. For PH1 (continuation): the patient has experienced decreased or normalized levels of urinary oxalate since initiating therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ROLVEDON

Products Affected

- Rolvedon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia, the patient must meet all of the following: 1) Patient has a solid tumor or non-myeloid cancer AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy AND 3) The requested drug will be administered at least 24 hours after chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer, the patient has recurrent, advanced, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Uterine leiomyosarcoma, pancreatic adenocarcinoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer
Exclusion Criteria	N/A
Required Medical Information	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, AND 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, AND 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated epithelial ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy, OR 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy, AND 2) the patient has BRCA-altered disease. For pancreatic adenocarcinoma: 1) the patient has metastatic disease, AND 2) the patient has somatic or germline BRCA or PALB-2 mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute angioedema attacks due to hereditary angioedema (HAE): Patient meets either of the following: 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	13 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an Immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

RUXIENCE

Products Affected

- Ruxience

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	<p>Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation from chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, Castleman disease, human immunodeficiency virus(HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLN, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, pediatric aggressive mature B-cell lymphomas, Rosai-Dorfman disease, and pediatric mature B-cell acute leukemia.</p>
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.</p>

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	The patient had an intolerable adverse event to Truxima and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

RYBELSUS

Products Affected

- Rybelsus

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulintropic polypeptide [GIP] and GLP-1 RAs).

RYBREVANT

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) mutation-positive disease
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer: 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-induction therapy for AML, re-induction in residual disease for AML
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYLAZE

Products Affected

- Rylaze

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Acute myeloid leukemia (AML), nasal type extranodal natural killer (NK)/T-cell lymphoma (ENKTL)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYPLAZIM

Products Affected

- Ryplazim

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYSTIGGO

Products Affected

- Rystiggo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYTELO

Products Affected

- Rytelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For new starts, patient meets all of the following: 1) patient has not responded to, has lost response to, or is ineligible for erythropoiesis-stimulating agents (ESAs), AND 2) patient has been receiving regular red blood cell transfusions as defined by greater than or equal to 4 units per 8 weeks. For continuation of therapy, patient meets all of the following: 1) patient must achieve or maintain red blood cell transfusion burden reduction, AND 2) patient must not experience an unacceptable toxicity on the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 weeks
Other Criteria	N/A

SAMSCA

Products Affected

- Samsca

- Tolvaptan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Therapy with the requested drug was initiated (or re-initiated) in the hospital.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

SANDOSTATIN LAR

Products Affected

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of thymomas and thymic carcinomas, tumor control of neuroendocrine tumors (NETs) of the pancreas, gastrointestinal tract, lung, thymus, unresected primary gastrinoma, well-differentiated grade 3 NETs, pheochromocytoma/paraganglioma.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. The requested drug will be used for tumor control for any of the following: 1) Neuroendocrine tumor (NET) of the gastrointestinal tract or pancreas in patients with recurrent, locoregional advanced disease and/or distant metastatic disease, OR 2) NET of the thymus or lung in patients with locoregional unresectable disease and/or distant metastatic disease, OR 3) Unresected primary gastrinoma, OR 4) Well-differentiated grade 3 unresectable locally advanced or metastatic NET with favorable biology (e.g., relatively low Ki-67 [less than 55%] and positive somatostatin receptor [SSTR]-based positron emission tomography [PET] imaging), OR 5) Thymomas or thymic carcinomas when the following criteria are met: a) Locally advanced or metastatic disease OR b) Postoperatively following tumor resection, OR 6) Pheochromocytomas or paragangliomas when the following criteria is met: a) Locally unresectable OR b) Distant metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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SAPHNELO

Products Affected

- Saphnelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will not be used in combination with other biologic therapies. For moderate to severe systemic lupus erythematosus (SLE): 1) Patient meets either of the following criteria: a) patient is receiving a stable standard therapy regimen (e.g., corticosteroid, antimalarial, or NSAIDs), OR b) patient has experienced an intolerance, or has a contraindication to standard therapy regimen for SLE, AND 2) For new starts: patient does not have severe active lupus nephritis or severe active central nervous system lupus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SAPROPTERIN

Products Affected

- Javygtor
- Kuvan
- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months, All others: Plan Year
Other Criteria	N/A

SARCLISA

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SAVELLA

Products Affected

- Savella

- Savella Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to duloxetine or pregabalin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SCSEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) in the chronic phase: 1) the diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND 2) the patient meets either of the following: A) the patient has previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least one of those was imatinib or dasatinib, OR B) the patient is positive for the T315I mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SEGLENTIS

Products Affected

- Seglentis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of acute pain: 1) Patient had an inadequate response to a two-pill regimen of tramadol and celecoxib OR 2) Patient has experienced an intolerance, or has a contraindication caused by an inactive ingredient in generic tramadol or generic celecoxib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SEROSTIM

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of human immunodeficiency virus (HIV) patients with wasting or cachexia: The requested medication is used in combination with antiretroviral therapy. Patient has had a suboptimal response to at least one other therapy for wasting or cachexia (e.g., megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) or patient has a contraindication or intolerance to alternative therapies. For continuation of therapy, patient must have demonstrated a response to therapy with the requested medication (i.e., body mass index [BMI] has increased or stabilized).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

SEYSARA

Products Affected

- Seysara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For inflammatory lesions of non-nodular moderate to severe acne vulgaris: 1) The patient has experienced an inadequate treatment response to doxycycline (regular or extended-release) or minocycline (regular or extended-release) OR 2) The patient has experienced an intolerance to doxycycline (regular or extended-release) or minocycline (regular or extended-release).
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

SIGNIFOR LAR

Products Affected

- Signifor Lar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery OR there is a clinical reason for why the patient has not had surgery. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIKLOS

Products Affected

- Siklos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SILDENAFIL

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SILDENAFIL INJ

Products Affected

- Revatio INJ
- Sildenafil INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	Patient was previously receiving oral Revatio or sildenafil but is now temporarily unable to take oral medications.

SILIQ

Products Affected

- Siliq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIMPONI

Products Affected

- Simponi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) requested drug will be used in combination with methotrexate (MTX) unless MTX is contraindicated or was not tolerated AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	N/A

SIMPONI ARIA

Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) requested drug will be used in combination with methotrexate (MTX) or MTX is contraindicated or was not tolerated AND 2) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For an adult with active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Plan Year
Other Criteria	N/A

SKYCLARYS

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Friedreich's ataxia (FRDA): 1) The patient has a confirmed genetic mutation in the frataxin (FXN) gene, AND 2) The patient is exhibiting clinical manifestations of the disease (e.g., muscle weakness, decline in coordination, frequent falling). For FRDA continuation of therapy: The patient has experienced a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in Friedreich's ataxia or a neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 600MG/10ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SKYTROFA AET

Products Affected

- Skytrofa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric patients with closed epiphyses
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Genotropin. If using target medication for a medically accepted indication not shared by Genotropin, then no trial of Genotropin is required for that target medication. Pediatric growth hormone deficiency (GHD), initial: A) Patient (pt) meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean, OR B) pt was diagnosed with GHD as a neonate. Pediatric GHD, continuation of therapy: Patient is experiencing improvement.
Age Restrictions	1 year of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year
Other Criteria	N/A

SOFOSBUVIR AND VELPATASVIR AET

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. The patient must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) AND the criteria will be applied consistent with current AASLD/IDSA guidance. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	N/A

SOGROYA AET

Products Affected

- Sogroya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Pediatric growth hormone deficiency (GHD): Pediatric patients with closed epiphyses
Required Medical Information	For all indications: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Genotropin. If using target medication for a medically accepted indication not shared by Genotropin, then no trial of Genotropin is required for that target medication. For adult GHD: Patient meets ANY of the following: 1) failed 2 pre-treatment growth hormone (GH) stimulation tests OR 2) pre-treatment insulin-like growth factor-1 (IGF-1) more than 2 standard deviations (SD) below mean AND failed 1 pre-treatment GH stimulation test. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrilen-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for a patient with a body mass index [BMI] 25-30 kg/m ² and high pretest probability of growth hormone deficiency [GHD] [e.g., acquired structural abnormalities] or BMI less than 25 kg/m ² , OR d) GST [peak GH level less than or equal to 1 ng/ml] in a patient with BMI 25-30 kg/m ² and low pretest probability of GHD or BMI greater than 30kg/m ²), OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-treatment IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defect, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS.
Age Restrictions	Pediatric growth hormone deficiency (GHD): 2.5 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Plan Year

Other Criteria	For pediatric growth hormone deficiency (GHD): A) Patient (pt) has pre-treatment (pre-tx) 1-year height (ht) velocity more than 2 standard deviations (SD) below mean OR a pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND pt meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean, OR B) Pt was diagnosed with GHD as a neonate.
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SOHONOS

Products Affected

- Sohonos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For reduction in volume of new heterotopic ossification in fibrodysplasia ossificans progressiva (FOP): The patient has a confirmed genetic mutation in the activin A receptor type I (ACVR1) gene.
Age Restrictions	8 years of age or older if female and 10 years of age or older if male
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOLIRIS

Products Affected

- Soliris

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) the diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by either: a) at least 5% PNH cells or b) at least 51% of GPI-AP deficient polymorphonuclear (PMN) cells AND 2) flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the patient (pt) has demonstrated a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels). For atypical hemolytic uremic syndrome (aHUS) (initial): the disease is not caused by Shiga toxin-producing Escherichia coli. For aHUS (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the pt has demonstrated a positive response to therapy (e.g., normalization of lactate dehydrogenase (LDH) levels, platelet counts). For generalized myasthenia gravis (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the pt has demonstrated a positive response to therapy (e.g., improvement in MG-ADL score). For neuromyelitis optica spectrum disorder (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the pt has demonstrated a positive response to therapy (e.g., reduction in number of relapses).</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year

Other Criteria	N/A
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SOMATULINE DEPOT

Products Affected

- Lanreotide Acetate

- Somatuline Depot

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tumor control of neuroendocrine tumors (NETs) of the lung, thymus or unresected primary gastrinoma, well-differentiated grade 3 neuroendocrine tumors not of gastroenteropancreatic origin, pheochromocytoma/paraganglioma.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control of neuroendocrine tumors (NETs) of the thymus or lung: Patient has locoregional unresectable, recurrent, and/or distant metastatic disease. For tumor control of well-differentiated grade 3 unresectable locally advanced or metastatic NETs (not of gastroenteropancreatic origin): Patient has favorable biology (e.g., relatively low Ki-67 [less than 55%] and positive somatostatin receptor [SSTR]-based positron emission tomography [PET] imaging). For tumor control of pheochromocytomas or paragangliomas: Patient has locally unresectable or distant metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOTYKTU

Products Affected

- Sotyktu

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SOVALDI AET

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For HCV: Infection confirmed by presence of HCV RNA in serum prior to starting treatment. The patient must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) AND the criteria will be applied consistent with current AASLD/IDSA guidance. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. For patients with genotype 1, 2, 3, or 4 infection and hepatocellular carcinoma awaiting liver transplantation: must meet MILAN criteria. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	MILAN criteria defined as: 1) tumor size 5 cm or less in diameter in patients with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3 cm or less in diameter in patients with multiple tumors, and 2) no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

SPEVIGO

Products Affected

- Spevigo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SPRIX

Products Affected

- Ketorolac Tromethamine NASAL SOLN 15.75MG/SPRAY

- Sprix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). In the setting of coronary artery bypass graft (CABG) surgery. Patients with active peptic ulcer disease or recent gastrointestinal bleeding or perforation. Patients with advanced renal disease or at risk for renal failure due to volume depletion. Use in labor and delivery. Use in patients with suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis, or those for whom hemostasis is critical. Concomitant use with probenecid or pentoxifylline.
Required Medical Information	For short term management of moderate to moderately severe pain: The patient is unable to tolerate oral medications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 days
Other Criteria	N/A

SPRYCEL

Products Affected

- Dasatinib

- Sprycel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene, and if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L, OR 2) Ph-like B-ALL with ABL-class kinase fusion, OR 3) relapsed or refractory T-cell ALL with ABL-class kinase fusion. For GIST, 1) the patient meets all of the following: A) the disease is unresectable, recurrent/progressive, or metastatic, B) the patient has received prior therapy with imatinib or avapritinib AND C) patients is positive for PDGFRA exon 18 mutations, OR 2) the requested drug is being used for palliation of symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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STELARA

Products Affected

- Stelara

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts): At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STIMUFEND

Products Affected

- Stimufend

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Stem cell transplantation-related indications
Exclusion Criteria	Use of the requested product less than 24 hours before or after chemotherapy.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Progressive gastrointestinal stromal tumors (GIST), osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, soft tissue sarcomas of the extremities, body wall, head and neck.
Exclusion Criteria	N/A
Required Medical Information	For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic. For colorectal cancer: The disease is advanced or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For the treatment of perinatal/infantile- and juvenile-onset hypophosphatasia: 1) The patient has clinical signs and/or symptoms of hypophosphatasia (e.g., generalized hypomineralization with rachitic features, chest deformities and rib fractures, respiratory problems, hypercalcemia, failure to thrive, bone/joint pain, seizures) AND 2) The onset of the disease was perinatal/infantile or juvenile AND 3) The diagnosis was confirmed by the presence of mutation(s) in the ALPL gene as detected by ALPL molecular genetic testing OR the diagnosis was supported by ALL of the following: a) radiographic imaging demonstrating skeletal abnormalities (e.g., infantile rickets, alveolar bone loss, focal bony defects of the metaphyses, metatarsal stress fractures), b) low serum alkaline phosphatase (ALP) level as defined by the gender- and age-specific reference range of the laboratory performing the test and c) elevated tissue-nonspecific alkaline phosphatase (TNALP) substrate level (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi] level).</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SUBLOCADE

Products Affected

- Sublocade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Prescribed only for the treatment of pain
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For excessive daytime sleepiness associated with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For excessive daytime sleepiness associated with obstructive sleep apnea (OSA), initial request: 1) The diagnosis has been confirmed by polysomnography, AND 2) The patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in daytime sleepiness with obstructive sleep apnea (OSA).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

SUSVIMO

Products Affected

- Susvimo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

SUTENT

Products Affected

- Sunitinib Malate

- Sutent

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia, pheochromocytoma, paraganglioma, gastrointestinal stromal tumor (GIST) (unresectable, recurrent/progressive, or metastatic disease after progression on approved therapies, unresectable succinate dehydrogenase (SDH)-deficient GISTs and use for palliation of symptoms if previously tolerated and effective).
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma (RCC): the patient meets either of the following: 1) the disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy. For gastrointestinal stromal tumor (GIST): the patient meets one of the following: 1) the requested drug will be used after disease progression on or intolerance to imatinib, 2) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib), 3) the requested drug will be used for unresectable succinate dehydrogenase (SDH)-deficient GIST, OR 4) the requested drug will be used for the palliation of symptoms if previously tolerated and effective. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) the disease has a FLT3 rearrangement AND 2) the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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SYFOVRE

Products Affected

- Syfovre

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

SYLVANT

Products Affected

- Sylvant

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed or refractory unicentric Castleman's disease in patients who are human immunodeficiency virus negative and human herpesvirus-8 negative
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Seizures associated with Dravet syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYNERA AET

Products Affected

- Synera

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response to a one month trial of generic topical lidocaine/prilocaine, or has an intolerance or contraindication to generic topical lidocaine/prilocaine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TADALAFIL (PAH)

Products Affected

- Adcirca
- Alyq
- Tadalafil TABS 20MG
- Tadliq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system (CNS) cancer (i.e., oligodendroglioma, astrocytoma, glioblastoma), gallbladder cancer, extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, Langerhans cell histiocytosis, Erdheim-Chester disease, ovarian cancer, fallopian tube cancer, and primary peritoneal cancer.
Exclusion Criteria	N/A
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, oligodendroglioma, astrocytoma, glioblastoma): 1) The tumor is positive for a BRAF V600E mutation AND 2) The requested drug will be used in combination with trametinib. For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and Hurthle cell thyroid carcinoma: 1) The tumor is BRAF-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For gallbladder cancer, extrahepatic cholangiocarcinoma, and intrahepatic cholangiocarcinoma: 1) The disease is positive for a BRAF V600E mutation, AND 2) The disease is unresectable or metastatic, AND 3) The requested drug will be used in combination with trametinib. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is persistent or recurrent, AND 3) The requested drug will be used in combination with trametinib.
Age Restrictions	N/A

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

TAGRISSEO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing EGFR mutation OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAKHZYRO

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of acute angioedema attacks due to hereditary angioedema (HAE): The patient meets either of the following: 1) the patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing and either of the following: a) patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR b) patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist, allergist, or rheumatologist
Coverage Duration	Plan Year
Other Criteria	N/A

TALTZ

Products Affected

- Taltz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab). For active ankylosing spondylitis (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (PsA) (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): patient meets any of the following: 1) patient has experienced an inadequate treatment response to a non-steroidal anti-inflammatory drug (NSAID) OR 2) patient has experienced an intolerance or has a contraindication to NSAIDs.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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TALVEY

Products Affected

- Talvey

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TARGRETIN TOPICAL

Products Affected

- Bexarotene GEL

- Targretin GEL

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TARPEYO

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For patients with primary immunoglobulin A nephropathy (IgAN) at risk of disease progression: 1) patient is on a stable dose of a maximally-tolerated renin-angiotensin system (RAS) inhibitor (e.g., angiotensin-converting enzyme [ACE] inhibitor or angiotensin-receptor blocker [ARB]) or patient has experienced an intolerance or has a contraindication to RAS inhibitors, AND 2) patient has experienced an intolerance to an oral glucocorticoid (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	10 months
Other Criteria	N/A

TASCENSO

Products Affected

- Tascenso Odt

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant, 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, 2) patient has experienced resistance or intolerance to imatinib or dasatinib, AND 3) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) if the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E. For gastrointestinal stromal tumor (GIST), the patients meets either of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the disease has progressed on at least 2 approved therapies (e.g. imatinib, sunitinib, dasatinib, regorafenib, ripretinib) OR 2) the requested drug is being prescribed for palliation of symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For chronic immune thrombocytopenia (ITP): 1) For new starts: patient meets all of the following: a) Patient has had an inadequate response or is intolerant to a prior therapy (e.g., corticosteroid, immunoglobulin, thrombopoietin receptor agonist), AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL or 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). 2) For continuation of therapy, platelet count response to the requested drug must meet one of the following: a) current platelet count is less than or equal to 200,000/mcL, OR b) current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 12 weeks, Reauthorization: Plan Year
Other Criteria	N/A

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazarotene GEL
- Tazorac

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, primary carcinoma of the urethra.
Exclusion Criteria	N/A
Required Medical Information	For primary carcinoma of the urethra: 1) Patient is ineligible for cisplatin therapy and tumors express PD-L1 OR 2) Patient is ineligible for any platinum containing chemotherapy. For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease AND the requested drug will be used as any of the following: a) first-line treatment of tumors with high PD-L1 expression (defined as PD-L1 stained greater than or equal to 50 percent of tumor cells or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10 percent of the tumor area) and no EGFR or ALK genomic tumor aberrations, b) used in combination with carboplatin, paclitaxel, and bevacizumab, or in combination with carboplatin and albumin-bound paclitaxel for non-squamous NSCLC, or c) the requested drug will be used as subsequent therapy or continuation maintenance therapy, OR 2) the patient has stage II to IIIA disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy for tumors with PD-L1 expression on greater than or equal to 1 percent of tumor cells. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECFIDERA

Products Affected

- Tecfidera

- Tecfidera Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECVAYLI

Products Affected

- Tecvayli

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For polyneuropathy of hereditary transthyretin-mediated amyloidosis initial therapy, patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease. For polyneuropathy of hereditary transthyretin-mediated amyloidosis continuation, patient demonstrates a beneficial response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TEMAZEPAM 30MG - 65

Products Affected

- Restoril CAPS 30MG
- Temazepam CAPS 30MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization only applies to patients 65 years of age or older.

TEPEZZA

Products Affected

- Tepezza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TERIFLUNOMIDE

Products Affected

- Teriflunomide

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsing MS [including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease]: Patient has experienced an intolerance to brand Aubagio due to an adverse event (e.g., rash, nausea, vomiting, anaphylaxis) caused by an inactive ingredient which is not contained in the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOPEL

Products Affected

- Testopel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOSTERONE AET

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Androgel Pump GEL 1.62%
- Natesto
- Testim
- Vogelxo
- Vogelxo Pump

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. For all indications: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to a generic testosterone gel.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOSTERONE CYPIONATE INJ

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TESTOSTERONE ENANTHATE INJ

Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

- Xenazine

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	N/A
Required Medical Information	For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease: The patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TEVIMBRA

Products Affected

- Tevimbra

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TEZSPIRE

Products Affected

- Tezspire

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For severe asthma, initial therapy: Patient has a history of severe asthma despite current treatment with both of the following medications: 1) medium-to-high-dose inhaled corticosteroid, 2) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myelofibrosis-associated anemia, AIDS-related aphthous stomatitis, Kaposi sarcoma, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Conventional (grades 1-3) or dedifferentiated chondrosarcoma. Newly-diagnosed acute myeloid leukemia (AML) if 60-74 years of age and without comorbidities.
Exclusion Criteria	N/A
Required Medical Information	Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML. For locally advanced, unresectable, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TIVDAK

Products Affected

- Tivdak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TLANDO

Products Affected

- Tlando

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOBI INHALER

Products Affected

- Tobii Podhaler

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOBRAMYCIN

Products Affected

- Bethkis
- Kitabis Pak
- Tobi
- Tobramycin NEBU

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-cystic fibrosis bronchiectasis
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOFIDENCE

Products Affected

- Tofidence

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Castleman's disease, systemic sclerosis-associated interstitial lung disease
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active systemic juvenile idiopathic arthritis (JIA) (new starts only): 1) patient has experienced an inadequate treatment response to a nonsteroidal anti-inflammatory drug (NSAID) trial, a corticosteroid, methotrexate, or leflunomide, OR 2) inadequate treatment response or intolerance to a prior biologic DMARD. For active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOLAK

Products Affected

- Tolak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients who are pregnant or may become pregnant. Patients with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	If being used as part of a compounded product, all active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

TOLSURA

Products Affected

- Tolsura

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

TOPICAL DOXEPIN

Products Affected

- Doxepin Hydrochloride CREA
- Prudoxin
- Zonalon

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

TOPICAL LIDOCAINE

Products Affected

- Dermacinrx Lidogel
- Glydo
- Lidocaine OINT 5%
- Lidocaine Hcl PRSY
- Lidocaine Hydrochloride EXTERNAL SOLN
- Lidorex
- Pliaglis CREA

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL TRETINOIN

Products Affected

- Altreno
- Atralin
- Avita
- Clindamycin Phosphate/tretinoin
- Retin-a CREA
- Retin-a GEL
- Retin-a Micro
- Retin-a Micro Pump
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump
- Twyneo
- Veltin
- Ziana

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOREMIFENE

Products Affected

- Fareston

- Toremifene Citrate

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRAMADOL ORAL SOLUTION

Products Affected

- Qdolo

- Tramadol Hydrochloride SOLN

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1) The patient has experienced an intolerance, caused by an inactive ingredient, to one other formulary product such as tramadol tablets, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRAZIMERA

Products Affected

- Trazimera

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor. For hepatobiliary carcinoma: 1) the disease is HER2 positive and 2) the requested drug is used in combination with pertuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRELSTAR

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender dysphoria, ovarian suppression in breast cancer
Exclusion Criteria	N/A
Required Medical Information	For gender dysphoria, patient meets either of the following (1 or 2): 1) the requested drug is used to suppress puberty and the patient is at Tanner stage 2 or greater, OR 2) patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones. For breast cancer: 1) requested drug is being used for ovarian suppression in premenopausal patients and 2) the requested drug will be used in combination with endocrine therapy and 3) the disease is hormone receptor positive and 4) the disease is at a higher risk of recurrence (e.g., young age, high-grade tumor, lymph-node involvement).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TREMFYA

Products Affected

- Tremfya INJ 100MG/ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TREPROSTINIL INJ

Products Affected

- Remodulin

- Treprostinil

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRIENTINE

Products Affected

- Syprine
- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRIPTODUR

Products Affected

- Triptodur

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	For CPP: Patient must be less than 12 years old if female and less than 13 years old if male
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRODELVY

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma, the requested drug will be used as subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder, c) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, d) recurrent primary carcinoma of the urethra, or e) stage II-IV urothelial carcinoma of the bladder. For breast cancer: 1) the disease is recurrent, advanced, or metastatic, AND 2) the requested drug will be used as subsequent therapy, AND 3) the patient has triple-negative, or hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRULICITY

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The Prior Authorization only applies to patients whose claim is not submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus OR to patients who do not have a history of an antidiabetic drug (EXCLUDING glucagon-like peptide receptor agonists [GLP-1 RAs] and combination glucose-dependent insulinotropic polypeptide [GIP] and GLP-1 RAs).

TRUQAP

Products Affected

- Truqap TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRUSELTIQ

Products Affected

- Truseltiq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TRUXIMA

Products Affected

- Truxima

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	<p>Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma, histological transformation from indolent lymphomas to diffuse large B-cell lymphoma, histological transformation chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, Castleman's disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTL, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, pediatric aggressive mature B-cell lymphomas, Rosai-Dorfman disease, and pediatric mature B-cell acute leukemia.</p>
Exclusion Criteria	N/A
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.</p>

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	N/A

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease AND 3) the patient has RAS wild-type disease AND 4) the requested drug will be used in combination with trastuzumab and 5) the patient has not previously been treated with a HER2 inhibitor.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease
Exclusion Criteria	N/A
Required Medical Information	For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation AND patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYENNE

Products Affected

- Tyenne

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Castleman's disease
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active systemic juvenile idiopathic arthritis (JIA) (new starts only): 1) patient has experienced an inadequate treatment response to a nonsteroidal anti-inflammatory drug (NSAID) trial, a corticosteroid, methotrexate, or leflunomide, OR 2) inadequate treatment response or intolerance to a prior biologic DMARD. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: adalimumab-aacf, Enbrel (etanercept), Humira (adalimumab), Idacio (adalimumab-aacf), Kevzara (sarilumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For osteoporosis in men: patient has ONE of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) a pre-tx T-score of less than or equal to -2.5 or pre-tx T-score greater than -2.5 and less than -1 with a high pre-tx FRAX fracture probability AND patient has ANY of the following: a) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, OR b) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months lifetime total for parathyroid hormone analogs

Other Criteria	Patient has high Fracture Risk Assessment Tool (FRAX) fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.
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TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one conventional therapy option (e.g., corticosteroids) AND one tumor necrosis factor (TNF) inhibitor indicated for Crohn's disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYVASO

Products Affected

- Tyvaso
- Tyvaso Refill Kit
- Tyvaso Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1) or pulmonary hypertension associated with interstitial lung disease (WHO Group 3) : the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TYVASO DPI

Products Affected

- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1) or pulmonary hypertension associated with interstitial lung disease (WHO Group 3) : the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TZIELD

Products Affected

- Tzield

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the delay of Stage 3 type 1 diabetes (T1D): 1) the patient has a diagnosis of Stage 2 T1D that was confirmed by both of the following: a) at least two positive pancreatic islet cell autoantibodies AND b) dysglycemia without overt hyperglycemia using an oral glucose tolerance test (OGTT) or alternative method if appropriate, AND 2) The clinical history of the patient does not suggest type 2 diabetes.
Age Restrictions	8 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 month
Other Criteria	N/A

UBRELVY

Products Affected

- Ubrelyvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT ₁ receptor agonist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ULTOMIRIS

Products Affected

- Ultomiris INJ 1100MG/11ML, 300MG/3ML

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) the diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) as demonstrated by either: a) at least 5% PNH cells or b) at least 51% of GPI-AP deficient polymorphonuclear (PMN) cells AND 2) flow cytometry is used to demonstrate GPI-AP deficiency. For PNH (continuation of therapy): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the patient has demonstrated a positive response to therapy (e.g., improvement in hemoglobin levels, normalization of lactate dehydrogenase [LDH] levels). For atypical hemolytic uremic syndrome: the disease is not caused by Shiga toxin-producing Escherichia coli. For neuromyelitis optica spectrum disorder (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the pt has demonstrated a positive response to therapy (e.g., reduction in number of relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PNH, NMOSD - initial: 6 months, All other: Plan Year
Other Criteria	N/A

UPLIZNA

Products Affected

- Uplizna

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

UPTRAVI

Products Affected

- Uptravi

- Uptravi Titration Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

UZEDY

Products Affected

- Uzedy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral risperidone has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VABOMERE

Products Affected

- Vabomere

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	14 days
Other Criteria	N/A

VABYSMO

Products Affected

- Vabysmo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Chronic or smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VALTOCO

Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VECAMYL

Products Affected

- Vecamyl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use in patients with coronary insufficiency, recent myocardial infarction, uremia, glaucoma, or organic pyloric stenosis.
Required Medical Information	For moderately severe to severe essential hypertension and uncomplicated cases of malignant hypertension, patient has a documented inadequate treatment response, intolerance, or contraindication to an adequate trial of one month of a two-drug combination from the preferred alternatives from the following classes: diuretics, angiotensin-converting enzyme inhibitors, angiotensin II receptor antagonists, beta-adrenergic blockers, calcium channel blockers.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VECTIBIX

Products Affected

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

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Appendiceal adenocarcinoma
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer, patient meets both of the following: 1) Tumor is negative (wild-type) for RAS (KRAS and NRAS) mutations, and 2) Patient has not previously experienced clinical failure on cetuximab. For appendiceal adenocarcinoma: 1) tumor is BRAF V600E positive and 2) the requested drug will be used in combination with encorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VEGZELMA

Products Affected

- Vegzelma

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VEKLURY

Products Affected

- Veklury INJ 100MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in a non-hospitalized patient all of the following are met: 1) patient is at high risk for progression to severe COVID-19 (e.g., age 60 or older, body mass index [BMI] 30 or greater, hypertension, diabetes mellitus, chronic lung disease), including hospitalization and death, AND 2) treatment with the requested drug is initiated within 7 days of symptom onset.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 Days
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VELCADE

Products Affected

- Bortezomib INJ 1MG, 2.5MG, 3.5MG

- Velcade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, Kaposi's sarcoma, Hodgkin lymphoma, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VELSIPITY

Products Affected

- Velsipity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: adalimumab-aacf, Humira (adalimumab), Idacio (adalimumab-aacf), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta

- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), myelodysplastic syndrome
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia (AML): 1) patient is 60 years of age or older, OR 2) patient is less than 60 years of age with unfavorable risk genetics and TP53-mutation, OR 3) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 4) patient has relapsed or refractory disease. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with dexamethasone, AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VEOPOZ

Products Affected

- Veopoz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For CD55-deficient protein-losing enteropathy (PLE), initial: Patient has a confirmed biallelic CD55 loss-of-function mutation detected by genotype analysis. For CD55-deficient PLE, continuation: 1) There is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) Patient demonstrates a positive response to therapy (e.g., normalization of serum albumin, improvement in signs and symptoms of disease).
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

VEOZAH

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERKAZIA

Products Affected

- Verkazia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to an ophthalmic mast cell stabilizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Rexulti, Secuado, Vraylar.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VEVYE

Products Affected

- Vevye

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For signs and symptoms of dry eye disease (DED): 1) Patient has experienced an inadequate treatment response or intolerance to Restasis (cyclosporine 0.05 percent emulsion) AND 2) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Xiidra (lifitegrast), Miebo (perfluorohexyloctane).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIBATIV AET

Products Affected

- Vibativ INJ 750MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Use of intravenous unfractionated heparin sodium.
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns. If culture shows susceptibility to vancomycin, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to vancomycin.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	1 month
Other Criteria	N/A

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VICTOZA AET

Products Affected

- Liraglutide
- Victoza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient meets both of the following: 1) The patient has a diagnosis of type 2 diabetes mellitus, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following: Bydureon (exenatide), Byetta (exenatide), Trulicity (dulaglutide), Ozempic (semaglutide), Rybelsus (semaglutide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIEKIRA AET

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C)
Required Medical Information	For hepatitis C virus (HCV): infection confirmed by presence of HCV RNA in the serum prior to starting treatment. The patient must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir). Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For cirrhosis/post-liver transplant: up to 24 weeks. All others: up to 12 weeks.
Other Criteria	N/A

VIGABATRIN

Products Affected

- Sabril
- Vigabatrin
- Vigadrone
- Vigpoder

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures).
Age Restrictions	Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIGAFYDE

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Infantile Spasms: 1 month to 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIJOICE

Products Affected

- Vijoje

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VILTEPSO

Products Affected

- Viltepsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIMIZIM

Products Affected

- Vimizim

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mucopolysaccharidosis type IVA (MPS IVA, Morquio A syndrome): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 6-sulfatase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
Exclusion Criteria	N/A
Required Medical Information	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIVJOA

Products Affected

- Vivjoa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	The patient is of reproductive potential.
Required Medical Information	To reduce the incidence of recurrent vulvovaginal candidiasis (RVVC) in a patient with a history of RVVC: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole AND 2) The requested drug will be used orally.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC).
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced or metastatic, and 2) the patient has sensitizing EGFR mutation-positive disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VORANIGO

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VORICONAZOLE

Products Affected

- Vfend SUSR
- Vfend IV
- Voriconazole INJ
- Voriconazole SUSR

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient will use the requested drug orally or intravenously.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

VOTRIENT

Products Affected

- Pazopanib Hydrochloride

- Votrient

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: 1) The disease is advanced, relapsed, or stage IV, OR 2) the requested drug will be used for von Hippel-Lindau (VHL)-associated renal cell carcinoma. For gastrointestinal stromal tumor (GIST): the patients meets one of the following: 1) the disease is unresectable, recurrent/progressive, or metastatic AND the patient has failed an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib), 2) the requested drug will be used for unresectable succinate dehydrogenase (SDH)-deficient GIST, OR 3) the requested drug will be used for the palliation of symptoms if previously tolerated and effective. For soft tissue sarcoma (STS): The patient does not have an adipocytic soft tissue sarcoma. For uterine sarcoma: The disease is recurrent or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

VOXZOGO

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For achondroplasia with open epiphyses, initial: The diagnosis is confirmed by either of the following: 1) radiological findings of characteristic features consistent with the disease OR 2) genetic testing. For achondroplasia with open epiphyses, continuation of therapy: patient is experiencing improvement.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, geneticist, neurologist, or skeletal dysplasia specialist
Coverage Duration	Plan Year
Other Criteria	N/A

VOYDEYA

Products Affected

- Voydeya

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For paroxysmal nocturnal hemoglobinuria (PNH) (initial): 1) the diagnosis of PNH was confirmed by detecting a deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) AND 2) flow cytometry is used to demonstrate GPI-AP deficiency AND 3) the requested drug is being used as add-on therapy to ravulizumab or eculizumab for the treatment of extravascular hemolysis (EVH). For PNH (continuation): 1) there is no evidence of unacceptable toxicity or disease progression while on the current regimen AND 2) the patient has demonstrated a positive response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For type 1 Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VTAMA

Products Affected

- Vtama

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis: The patient has experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial with topical corticosteroids.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VUITY

Products Affected

- Vuity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For treatment of presbyopia, continuation: Patient experiences improvement from baseline presbyopia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months, Continuation: Plan Year
Other Criteria	N/A

VUMERITY

Products Affected

- Vumerity

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYEPTI

Products Affected

- Vyepti

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Continuation: Plan Year
Other Criteria	N/A

VYJUVEK

Products Affected

- Vyjuvek

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will not be administered to wound(s) that are currently healed.
Age Restrictions	6 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or wound care specialist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cardiomyopathy of hereditary or wild-type transthyretin-mediated amyloidosis (ATTR-CM): Initiation: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), AND 3) patient meets one of the following: a) if the request is for hereditary ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene, b) if the request is for wild-type ATTR-CM the patient has transthyretin precursor proteins confirmed by testing. Continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For cardiomyopathy of hereditary or wild-type transthyretin-mediated amyloidosis (ATTR-CM): Initiation: 1) patient exhibits clinical manifestation of disease (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema), AND 2) cardiac involvement was confirmed by echocardiography or cardiac magnetic resonance imaging (e.g., end-diastolic interventricular septal wall thickness exceeding 12 millimeters), AND 3) patient meets one of the following: a) if the request is for hereditary ATTR-CM the patient is positive for a mutation of the transthyretin (TTR) gene, b) if the request is for wild-type ATTR-CM the patient has transthyretin precursor proteins confirmed by testing. Continuation: patient demonstrates a beneficial response to therapy (e.g., slowing of clinical decline).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYONDYS 53

Products Affected

- Vyondys 53

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYVGART

Products Affected

- Vyvgart

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYVGART HYTRULO

Products Affected

- Vyvgart Hytrulo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VYXEOS

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Antecedent myelodysplastic syndrome/chronic myelomonocytic leukemia (MDS/CMML)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	Plan Year
Other Criteria	N/A

WAINUA

Products Affected

- Wainua

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For polyneuropathy of hereditary transthyretin (TTR)-mediated amyloidosis, initial therapy: Patient is positive for a mutation of the TTR gene and exhibits clinical manifestation of disease (for example, amyloid deposition in biopsy specimens, TTR protein variants in serum, progressive peripheral sensory-motor polyneuropathy). For polyneuropathy of hereditary TTR-mediated amyloidosis, continuation: Patient demonstrates a beneficial response to therapy (for example, improvement of neuropathy severity and rate of disease progression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

WAKIX

Products Affected

- Wakix

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) If the request is for an adult, the patient experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. For continuation of therapy: The patient has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	Cataplexy: 18 years of age or older, Excessive Daytime Sleepiness: 6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For advanced renal cell carcinoma (RCC): 1) patient previously received treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor, AND 2) patient previously received treatment with a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Cabometyx (cabozantinib), Inlyta (axitinib), Nexavar (sorafenib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

WINLEVI

Products Affected

- Winlevi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance or the patient has a contraindication to a generic acne product (e.g., topical clindamycin, topical erythromycin, topical retinoid, or oral isotretinoin).
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

WINREVAIR

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic ALK-positive NSCLC, OR 2) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, OR 3) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT, the disease is ALK-positive. For ALCL, the disease is relapsed or refractory and ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XDEMZY

Products Affected

- Xdemzy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz

- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For active psoriatic arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]) AND 2) the requested drug is used in combination with a nonbiologic DMARD. For active ankylosing spondylitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf]). For active polyarticular course juvenile idiopathic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A
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XEMBIFY

Products Affected

- Xembify

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

XENLETA

Products Affected

- Xenleta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

XENPOZYME

Products Affected

- Xenpozyme

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acid sphingomyelinase deficiency (ASMD): The diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid sphingomyelinase (ASM) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XEOMIN

Products Affected

- Xeomin

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

XHANCE MAPD

Products Affected

- Xhance

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient has experienced an inadequate treatment response to generic fluticasone nasal spray.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XIAFLEX

Products Affected

- Xiaflex

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Cosmetic use (e.g., cellulite treatment)
Required Medical Information	<p>For Dupuytren's contracture: 1) patient has a finger flexion contracture with a palpable cord in a metacarpophalangeal joint or a proximal interphalangeal joint, AND 2) the contracture is at least 20 degrees, AND 3) patient has a positive table top test, defined as the inability to simultaneously place the affected finger(s) and palm flat against a table.</p> <p>For Peyronie's disease: 1) the requested drug is not used to treat Peyronie's plaques that involve the penile urethra, AND 2) for initiation of therapy, patient has a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees with intact erectile function (with or without medication) at the start of therapy, AND 3) for continuation of therapy, the curvature deformity is 15 degrees or greater.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Dupuytren's contracture: 6 months. Peyronie's disease: 12 months.
Other Criteria	N/A

XIFAXAN

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug OR 2) The patient has previously received treatment with the requested drug AND a) the patient is experiencing a recurrence of symptoms AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Reduction in risk of overt HE recurrence: 6 Months, IBS-D: 14 Days
Other Criteria	N/A

XIFAXAN200

Products Affected

- Xifaxan TABS 200MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 Days
Other Criteria	N/A

XIPERE

Products Affected

- Xipere

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For moderate to severe persistent asthma, initial therapy: 1) Patient has a positive skin test (or blood test) to at least one perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, AND 3) Patient has inadequate asthma control despite current treatment with both of the following medications: a) Medium-to-high-dose inhaled corticosteroid, AND b) Additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate to severe persistent asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For chronic spontaneous urticaria (CSU), initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (e.g., auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, AND 3) Patient remains symptomatic despite H1 antihistamine treatment. For CSU, continuation of therapy: Patient has experienced a benefit (e.g., improved symptoms) since initiation of therapy. For chronic rhinosinusitis with nasal polyps (CRSwNP): 1) The requested drug is used as add-on maintenance treatment, AND 2) Patient has experienced inadequate treatment response to Xhance (fluticasone).</p>
Age Restrictions	CSU: 12 years of age or older. Asthma: 6 years of age or older. CRSwNP: 18 years of age or older. IgE-mediated food allergy: 1 year of age or older
Prescriber Restrictions	N/A

Coverage Duration	CSU initial: 6 months, All others: Plan Year
Other Criteria	For IgE-mediated food allergy, initial therapy: Patient has baseline IgE level greater than or equal to 30 IU/mL. For IgE-mediated food allergy, continuation of therapy: Patient has experienced a benefit as evidenced by a decrease in hypersensitivity (e.g., moderate to severe skin, respiratory or gastrointestinal symptoms) to food allergen.

XOLREMDI

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis), initial: 1) Diagnosis has been confirmed via testing to detect mutations in the CXCR4 gene AND 2) The patient exhibits at least one clinical manifestation of the disease (such as warts, hypogammaglobulinemia, infections, myelokathexis) AND 3) The patient has a confirmed low neutrophil count based on the reference laboratory range or current practice guidelines. For WHIM syndrome, continuation: The patient has demonstrated a positive response to therapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement
Exclusion Criteria	N/A
Required Medical Information	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XPHOZAH

Products Affected

- Xphozah

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XPOVIO

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, high-grade B-cell lymphoma
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: Patient must have been treated with at least one prior therapy. For B-cell lymphomas: Patient must have been treated with at least two lines of systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For orotic aciduria type 1 (OA1) (hereditary orotic aciduria): Diagnosis is confirmed by one of the following: 1) biochemical test detecting elevated levels of orotic acid in the urine or 2) genetic test showing mutations in the uridine monophosphate synthetase (UMPS) gene. For OA1, continuation: Patient's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months, Continuation: Plan Year
Other Criteria	N/A

XYOSTED AET

Products Affected

- Xyosted

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Gender Dysphoria
Exclusion Criteria	N/A
Required Medical Information	For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. For all indications: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to a generic topical testosterone gel AND one of the following: generic testosterone enanthate or generic testosterone cypionate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XYREM

Products Affected

- Sodium Oxybate

- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of excessive daytime sleepiness in a patient with narcolepsy, initial request: 1) The diagnosis has been confirmed by sleep lab evaluation, AND 2) The patient meets one of the following criteria: a) if the patient is 17 years of age or younger, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate), OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate), b) If the patient is 18 years of age or older, the patient has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil, modafinil). For the treatment of cataplexy in a patient with narcolepsy, initial request: The diagnosis has been confirmed by sleep lab evaluation. If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

XYWAV

Products Affected

- Xywav

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>For the treatment of excessive daytime sleepiness in a patient (pt) with narcolepsy, initial request: 1) the diagnosis (dx) has been confirmed by sleep lab evaluation, AND 2) the pt meets one of the following criteria: a) If the pt is 17 years of age or younger, the pt has experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, methylphenidate), OR has a contraindication that would prohibit a trial of CNS stimulant drugs (e.g., amphetamine, dextroamphetamine, methylphenidate), b) If the pt is 18 years of age or older, the pt has experienced an inadequate treatment response or intolerance to at least one CNS wakefulness promoting drug (e.g., armodafinil, modafinil), OR has a contraindication that would prohibit a trial of CNS wakefulness promoting drugs (e.g., armodafinil, modafinil). For idiopathic hypersomnia the diagnosis has been confirmed by ALL of the following: 1) pt has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) insufficient sleep syndrome is confirmed absent, AND 3) cataplexy is absent, AND 4) fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results.</p>
Age Restrictions	Narcolepsy: 7 years of age or older, Idiopathic hypersomnia: 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a sleep disorder specialist or neurologist

Coverage Duration	Plan Year
Other Criteria	For the treatment of cataplexy in a pt with narcolepsy, initial request: the dx has been confirmed by sleep lab evaluation. For narcolepsy, continuation of therapy: the pt has experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. For idiopathic hypersomnia, continuation of therapy: the pt has experienced a decrease in daytime sleepiness from baseline.

YCANTH

Products Affected

- Ycanth

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Soft tissue sarcoma (extremity/body wall or head/neck, retroperitoneal/intra-abdominal, rhabdomyosarcoma, solitary fibrous tumor)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	Plan Year
Other Criteria	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

YUPELRI AET

Products Affected

- Yupelri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following: Breo Ellipta (fluticasone/vilanterol), fluticasone/salmeterol, Incruse Ellipta (umeclidinium), Anoro Ellipta (umeclidinium/vilanterol), Bevespi (glycopyrrolate/formoterol), Serevent Diskus (salmeterol), Trelegy Ellipta (fluticasone/umeclidinium/vilanterol), Wixela.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

ZALTRAP

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Unresectable colorectal cancer.
Exclusion Criteria	N/A
Required Medical Information	For advanced, unresectable, or metastatic colorectal cancer (including appendiceal adenocarcinoma): the requested drug will be used in combination with FOLFIRI or irinotecan.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplant, hematopoietic syndrome of acute radiation syndrome
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ZAVZPRET

Products Affected

- Zavzpret

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For acute migraine: 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to Nurtec ODT (rimegepant) OR Ubrovelvy (ubrogepant).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEGERID CAPSULE AET

Products Affected

- Zegerid CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has an intolerance or a contraindication to OR has experienced an inadequate treatment response to a one-month trial of TWO of the following formulary generic proton pump inhibitors (PPIs): lansoprazole, omeprazole, omeprazole/bicarbonate, pantoprazole, esomeprazole sodium, or esomeprazole magnesium.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEGERID SUSPENSION AET

Products Affected

- Zegerid PACK

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For all indications except the reduction of risk of upper GI bleed in critically ill patients: the patient has an intolerance or a contraindication to OR has experienced an inadequate treatment response to a one-month trial of TWO of the following formulary generic proton pump inhibitors (PPIs): lansoprazole, omeprazole, omeprazole/bicarbonate, pantoprazole, esomeprazole sodium, or esomeprazole magnesium.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEJULA

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Uterine leiomyosarcoma
Exclusion Criteria	N/A
Required Medical Information	For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.
Exclusion Criteria	N/A
Required Medical Information	For central nervous system (CNS) cancer (i.e., glioma, astrocytoma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease. For papillary, follicular, and hurthle cell thyroid carcinoma: 1) The tumor is positive for BRAF mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEMDRI

Products Affected

- Zemdri

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	14 days
Other Criteria	N/A

ZEPATIER AET

Products Affected

- Zepatier

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Hepatitis C genotype 3 infection
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. The patient must have a contraindication or intolerance to 2 of the following, if appropriate, based on current AASLD/IDSA guidance: Epclusa (velpatasvir and sofosbuvir), Harvoni (ledipasvir and sofosbuvir), Mavyret (glecaprevir and pibrentasvir), Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) AND the criteria will be applied consistent with current AASLD-IDSA guidance. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions (e.g., NS5A polymorphisms) where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

ZEPOSIA

Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one conventional therapy (e.g., corticosteroids).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEPZELCA

Products Affected

- Zepzelca

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Relapsed small cell lung cancer, primary progressive small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	For small cell lung cancer: the requested medication will be used as a single agent in one of the following settings: 1) the disease has relapsed following complete or partial response or stable disease with initial treatment, 2) the patient has primary progressive disease, or 3) the patient has metastatic disease following disease progression on or after platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZILBRYSQ

Products Affected

- Zilbrysq

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZILXI

Products Affected

- Zilxi

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic topical metronidazole or topical azelaic acid 15 percent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

ZIRABEV

Products Affected

- Zirabev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Ampullary adenocarcinoma, breast cancer, central nervous system (CNS) cancers, malignant pleural mesothelioma, malignant peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

ZOKINVY

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For Hutchinson-Gilford Progeria Syndrome and for processing-deficient Progeroid Laminopathy with heterozygous LMNA mutation with progerin-like protein accumulation or homozygous or compound heterozygous ZMPSTE24 mutations: 1) diagnosis is confirmed by genetic testing AND 2) patient has a body surface area of 0.39 meters squared or above.
Age Restrictions	12 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolanza

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Mycosis fungoides (MF)/Sezary syndrome (SS)
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZOLPIDEM CAP

Products Affected

- Zolpidem Tartrate CAPS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For insomnia: The patient has experienced an inadequate treatment response or intolerance to zolpidem immediate-release tablets.
Age Restrictions	Less than 65 years of age
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZONISADE

Products Affected

- Zonisade

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZORBTIVE

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist.
Coverage Duration	Plan Year
Other Criteria	N/A

ZORYVE

Products Affected

- Zoryve CREA 0.3%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis: The patient has experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR the patient has a contraindication that would prohibit a trial with topical corticosteroids.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZORYVE 0.15 PERCENT CREAM

Products Affected

- Zoryve CREA 0.15%

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For mild to moderate atopic dermatitis, the patient meets either of the following criteria: 1) If the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor.
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZORYVE FOAM

Products Affected

- Zoryve FOAM

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For seborrheic dermatitis: If the patient is 12 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to topical ketoconazole.
Age Restrictions	9 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZTLIDO AET

Products Affected

- Ztlido

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	N/A
Required Medical Information	For all indications: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to generic lidocaine patches. For post-herpetic neuralgia (PHN): patient has experienced an inadequate treatment response to one month of gabapentin or has an intolerance or contraindication to gabapentin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZURZUVAE

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Small lymphocytic lymphoma (SLL)
Exclusion Criteria	N/A
Required Medical Information	For CLL/SLL: the requested drug is used as second-line or subsequent therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Recurrent ALK-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC: the patient has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYMFENTRA AET

Products Affected

- Zymfentra 2-pen
- Zymfentra 2-syringe

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYNLONTA

Products Affected

- Zynlonta

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specified) and histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used as second-line or subsequent therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYNYZ

Products Affected

- Zynyz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- Zyprexa Relprevv

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 50MG
- Akynzeo CAPS
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Alkeran TABS
- Ambisome
- Amphotericin B INJ
- Amphotericin B Liposome
- Anzemet TABS 50MG
- Aprepitant CAPS
- Astagraf XL
- Atgam
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Baclofen INJ 20000MCG/20ML, 40MG/20ML, 500MCG/ML, 50MCG/ML
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cellcept
- Cellcept Intravenous
- Cladribine
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 6/5
- Clinimix 8/10
- Clinimix 8/14
- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 8/10
- Clinimix E 8/14
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine INJ 100MG/ML
- Cytarabine Aqueous
- Deferoxamine Mesylate
- Depo-medrol
- Desferal INJ 500MG
- Dextrose 25% INJ 250MG/ML
- Dextrose 50%
- Dextrose 70%
- Dilaudid INJ 0.2MG/ML, 1MG/ML, 2MG/ML
- Dobutamine Hcl INJ 250MG/20ML
- Dobutamine Hcl/d5w INJ 5%; 1MG/ML
- Dobutamine Hydrochloride/dextrose 5%
- Dopamine Hydrochloride INJ
- Dopamine Hydrochloride/dextrose
- Dopamine/d5w INJ 5%; 3.2MG/ML

- Doxorubicin Hcl INJ 50MG
- Doxorubicin Hydrochloride INJ 10MG, 200MG/100ML
- Duopa
- Duramorph
- Emend CAPS 80MG
- Emend SUSR
- Emend Tripack
- Engerix-b
- Envarsus Xr
- Epoprostenol Sodium
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML, 500MCG/10ML, 50MCG/ML
- Fiasp Pumpcart
- Flolan
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Gablofen
- Gamastan
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Hepatamine INJ 62MEQ/L; 770MG/100ML; 600MG/100ML; 3MEQ/L; 20MG/100ML; 900MG/100ML; 240MG/100ML; 900MG/100ML; 1100MG/100ML; 610MG/100ML; 100MG/100ML; 100MG/100ML; 115MG/100ML; 800MG/100ML; 500MG/100ML; 450MG/100ML; 66MG/100ML; 840MG/100ML
- Heplisav-b
- Humulin R U-500 (concentrated)
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 4MG/ML
- Hydromorphone Hydrochloride INJ 0.25MG/0.5ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML
- Hyperlyte-cr
- Imovax Rabies (h.d.c.v.)
- Imuran TABS
- Infumorph 200
- Infumorph 500
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Isolyte-s INJ 27MEQ/L; 98MEQ/L; 23MEQ/L; 3MEQ/L; 5MEQ/L; 140MEQ/L
- Isolyte-s Ph 7.4
- Jynneos
- Kabiven
- Khapzory
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Medrol TABS 16MG, 2MG, 4MG, 8MG
- Melphalan
- Methylprednisolone TABS
- Methylprednisolone Acetate INJ 40MG/ML, 80MG/ML
- Methylprednisolone Sodium Succinate
- Methylprednisolone Sodiumsuccinate INJ 40MG
- Millipred TABS
- Milrinone Lactate INJ 10MG/10ML, 20MG/20ML, 50MG/50ML
- Milrinone Lactate In Dextrose
- Mitigo
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Morphine Sulfate/sodium Chloride INJ 1MG/ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil INJ
- Mycophenolate Mofetil SUSR

- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myfortic
- Myhibbin
- Nebupent
- Neoral
- Nulojix
- Nutrilipid
- Omegaven
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Orapred Odt
- PEDIAPRED SOLN
- Pentamidine Isethionate INHALATION SOLR
- Perikabiven
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prednisolone SOLN
- Prednisolone TABS
- Prednisolone Sodium Phosphate ORAL SOLN 10MG/5ML, 15MG/5ML, 20MG/5ML, 25MG/5ML, 5MG/5ML
- Prednisolone Sodium Phosphate Odt
- Prednisone SOLN
- Prednisone TABS 10MG, 1MG, 2.5MG, 20MG, 50MG, 5MG
- Prednisone Intensol
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prialt
- Prograf
- Prosol
- Pulmicort
- Rabavert
- Rapamune
- Rayos
- Recombivax Hb
- Sandimmune CAPS 100MG, 25MG
- Sandimmune INJ
- Sandimmune SOLN
- Simulect
- Sirolimus SOLN
- Sirolimus TABS
- Smoflipid
- Solu-medrol INJ 1000MG, 125MG, 2GM, 40MG, 500MG
- Tacrolimus CAPS
- Thymoglobulin
- Tpn Electrolytes INJ 29.5MEQ/20ML; 4.5MEQ/20ML; 35MEQ/20ML; 5MEQ/20ML; 20MEQ/20ML; 35MEQ/20ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML

- Trophamine INJ 0.54GM/100ML;
1.2GM/100ML; 0.32GM/100ML; 0; 0;
0.5GM/100ML; 0.36GM/100ML;
0.48GM/100ML; 0.82GM/100ML;
1.4GM/100ML; 1.2GM/100ML;
0.34GM/100ML; 0.48GM/100ML;
0.68GM/100ML; 0.38GM/100ML;
5MEQ/L; 0.025GM/100ML;
0.42GM/100ML; 0.2GM/100ML;
0.24GM/100ML; 0.78GM/100ML
- Varubi TBPk
- Veletri
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ 1MG/ML
- Zortress
- Zulresso

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	853	Adalimumab-ryvk	10
Abilify Asimtufii	1	Adalimumab-ryvk (2 Pen)	10
Abilify Mycite	2	Adapalene	13
Abilify Mycite Maintenance Kit	2	Adapalene Pump	13
Abilify Mycite Starter Kit	2	Adapalene/benzoyl Peroxide	13
Abiraterone	4	Adbry	14
Abiraterone Acetate	4	Adcirca	660
Abrilada	10	Adempas	15
Abrilada 1-pen Kit	10	Adlarity	16
Absorica	334	Adriamycin	853
Accutane	334	Adzyna	17
Acetylcysteine	853	Afinitor	209
Acitretin	5	Afinitor Disperz	209
Actemra	6	Agamree	18
Actemra Actpen	6	Aimovig	19
Acthar	7	Ajovy	20
Acthar Gel	7	Akeega	21
Acthar Hp	7	Aklief	22
Actimmune	8	Akynzeo	853
Acyclovir Sodium	853	Albuterol Sulfate	853
Adakveo	9	Aldurazyme	23
Adalimumab Aet	10	Alecensa	24
Adalimumab-aacf (2 Pen)	306	Aliqopa	25
Adalimumab-aacf (2 Syringe)	306	Alkeran	853
Adalimumab-aaty 1-pen Kit	10	Alkindi	26
Adalimumab-aaty 2-pen Kit	10	Alkindi Sprinkle	26
Adalimumab-aaty 2-syringe Kit	10	Allzital	91
Adalimumab-adaz	10	Alosetron	27
Adalimumab-adbm	10	Alosetron Hydrochloride	27
Adalimumab-adbm Crohns/uc/hs Starter	10	Alpha1-proteinase Inhibitor	28
Adalimumab-adbm Psoriasis/uveitis Starter	10	Altreno	703
Adalimumab-adbm Starter Package For Crohns Disease/uc/hs	10	Alunbrig	29
Adalimumab-adbm Starter Package For Psoriasis/uveitis	10	Alvaiz	30
Adalimumab-fkjp	10	Alyglo	338
		Alymsys	32
		Alyq	660
		Ambien	280
		Ambien Cr	280

Ambisome	853	Augtyro	48
Ambrisentan	33	Auryxia	49
Amitiza	34	Austedo	50
Amitiza Aet	34	Austedo Xr	50
Amitriptyline Hcl	290	Austedo Xr Patient Titration Kit	50
Amitriptyline Hydrochloride	290	Auvelity	51
Amjevita	10	Avastin	52
Amnesteem	334	Avita	703
Amondys 45	35	Avonex	53
Amphotericin B	853	Avonex Aet	53
Amphotericin B Liposome	853	Avonex Pen	53
Ampyra	143	Avsola	54
Amrix	295	Avycaz	56
Amvuttra	36	Ayvakit	57
Anafranil	122	Azasan	853
Anaspaz	276	Azathioprine	853
Ancobon	235	B	
Androderm	686	Baclofen	234, 853
Androgel Pump	686	Bafiertam	58
Anzemet	853	Bafiertam Aet	58
Apokyn	37	Balversa	59
Apomorphine Hydrochloride	37	Banzel	60
Aprepitant	853	Bavencio	61
Aralast Np	28	Baxdela	62
Aranesp Aet	38	Belbuca	63
Aranesp Albumin Free	38	Beleodaq	64
Arcalyst	40	Belladonna/opium	276
Arestin	41	Benlysta	65
Arestin Aet	41	Bentyl	276
Arformoterol Tartrate	87	Benznidazole	66
Arikayce	42	Benztropine Mesylate	283
Armodafinil	43	Beovu	67
Arzerra	44	Berinert	68
Asceniv	338	Besponsa	69
Ascomp/codeine	91	Besremi	70
Asparlas	45	Betaseron	71
Aspruzyo	46	Bethkis	697
Aspruzyo Sprinkle	46	Bexarotene	72, 669
Astagraf XL	853	Bimzelx	73
Atgam	853	Bivigam	338
Atovaquone	423	Blenrep	74
Atralin	703	Bleomycin Sulfate	853
Atropine Sulfate	276	Blincyto	75
Aubagio	47	Bortezomib	742
			858

Bosentan.....	76	Calcitrene.....	98
Bosulif.....	77	Calcitriol.....	98
Botox.....	78	Calquence.....	99
Braftovi.....	79	Cambia.....	100
Brisdelle.....	80	Camzyos.....	101
Briumvi.....	81	Caprelsa.....	102
Briumvi Aet.....	81	Carac.....	103
Briviact.....	82, 83	Carbaglu.....	104
Briviact Inj.....	83	Carbinoxamine Maleate.....	291
Brixadi.....	84	Carglumic Acid.....	104
Bromfenac Sodium.....	85, 540	Carisoprodol.....	295
Bromsite Aet.....	85	Cayston.....	105
Bronchitol.....	86	Cellcept.....	853
Bronchitol Tolerance Test.....	86	Cellcept Intravenous.....	853
Brovana.....	87	Cequa.....	106
Brovana Aet.....	87	Cerdelga.....	107
Brukinsa.....	88	Cerezyme.....	108
Bruselix.....	240	Chantix Aet.....	109
Budesonide.....	853	Chenodal.....	110
Bupap.....	91	Chenodal Aet.....	110
Buphenyl.....	521	Chlordiazepoxide - 65.....	111
Buprenorphine.....	89, 90	Chlordiazepoxide Hcl.....	111
Buprenorphine Hcl.....	89	Chlordiazepoxide Hydrochloride.....	111
Buprenorphine Patch.....	90	Chlordiazepoxide Hydrochloride/clidinium Bromide.....	386
Butalbital Aet.....	91	Chlordiazepoxide/amitriptyline.....	276
Butalbital/acetaminophen.....	91	Chlorzoxazone.....	295
Butalbital/acetaminophen/caffeine.....	91	Cholbam.....	112
Butalbital/acetaminophen/caffeine/codeine.....	91	Chorionic Gonadotropin.....	261
Butalbital/aspirin/caffeine.....	91	Cibinqo.....	113
Butalbital/aspirin/caffeine/codeine.....	91	Cimerli.....	114
Butrans.....	90	Cimzia.....	115
Bydureon.....	92	Cimzia Starter Kit.....	115
Bydureon Bcise.....	92	Cinqair.....	117
Byetta.....	93	Cinryze.....	118
Bylvay.....	94	Cinvanti.....	119
Bylvay (pellets).....	94	Citalopram Cap Aet.....	120
Byooviz.....	95	Citalopram Hydrobromide.....	120
C		Cladribine.....	853
Cablivi.....	96	Claravis.....	334
Cabometyx.....	97	Clemastine Fumarate.....	292
Cabtreo.....	13	Clindamycin Phosphate/tretinoin.....	703
Calcipotriene.....	98	Clinimix 4.25%/dextrose 10%.....	853
Calcipotriene/betamethasone Dipropionate.....	98	Clinimix 4.25%/dextrose 5%.....	853
Calcitonin Salmon.....	427		

Clinimix 5%/dextrose 15%	853	Cycloset Aet.....	139
Clinimix 5%/dextrose 20%	853	Cyclosporine	853
Clinimix 6/5	853	Cyclosporine Modified	853
Clinimix 8/10	853	Cyltezo	10
Clinimix 8/14	853	Cyltezo Starter Package For Crohns Disease/uc/hs	10
Clinimix E 2.75%/dextrose 5%.....	853	Cyltezo Starter Package For Psoriasis	10
Clinimix E 4.25%/dextrose 10%.....	853	Cyltezo Starter Package For Psoriasis/uveitis.....	10
Clinimix E 4.25%/dextrose 5%.....	853	Cyproheptadine Hcl	284
Clinimix E 5%/dextrose 15%.....	853	Cyproheptadine Hydrochloride.....	284
Clinimix E 5%/dextrose 20%.....	853	Cyramza	140
Clinimix E 8/10	853	Cystadrops.....	142
Clinimix E 8/14	853	Cystagon	141
Clinisol Sf 15%	853	Cystaran	142
Clinolipid.....	853	Cytarabine	853
Clobazam.....	121	Cytarabine Aqueous.....	853
Clomipramine.....	122	D	
Clomipramine Hydrochloride	122	Dalfampridine	143
Clorazepate.....	123	Dalfampridine Er	143
Clorazepate Dipotassium.....	123	Dapagliflozin Aet.....	144
Clozapine Odt.....	124	Dapagliflozin Propanediol	144
Cocaine Hydrochloride	262	Dapagliflozin Propanediol/metformin Hydrochloride	145
Colistimethate Sodium	126	Dapagliflozin-metformin Aet.....	145
Columvi.....	125	Daraprim	146
Coly-mycin.....	126	Darzalex	147
Coly-mycin M	126	Darzalex Faspro	148
Cometriq.....	127	Dasatinib	642
Copaxone.....	259	Daurismo.....	149
Copiktra.....	128	Daybue	150
Cortrophin	129	Deferasirox.....	151
Cosentyx.....	130	Deferiprone	225
Cosentyx Sensoready Pen	130	Deferoxamine Mesylate	853
Cosentyx Unoready.....	130	Deflazacort.....	180
Cotellic	132	Demerol.....	276
Crinone	133	Demser	152
Cromolyn Sodium	853	Depo-medrol	853
Crysvita	134	Depo-testosterone	687
Cutaquig	135	Dermacinrx Lidogel.....	702
Cuvitru.....	136	Desferal	853
Cuvrior	137	Desipramine Hydrochloride.....	290
Cyclobenzaprine Hydrochloride	295	Desvenlafaxine.....	153
Cyclobenzaprine Hydrochloride Er.....	295	Desvenlafaxine Er.....	153
Cyclophosphamide.....	138	Dextrose 25%.....	853
Cyclophosphamide Oral.....	138		860
Cycloset.....	139		

Dextrose 50%	853	Duopa	854
Dextrose 70%	853	Dupixent	167
Dhe Nasal	154	Duramorph	854
Diacomit	155	Durysta	169
Diazepam	156	Duvyzat	170
Diazepam Aet	156	Dyclopro	171
Diazepam Intensol	156	Dysport	172
Dichlorphenamide	359	<i>E</i>	
Diclofenac 1.5% Sol	157	Edaravone	555
Diclofenac 2% Sol	158	Edluar	280
Diclofenac 3% Gel	159	Efudex	236
Diclofenac Epolamine	233	Egrifta	173
Diclofenac Potassium	100, 299	Egrifta Sv	173
Diclofenac Sodium	157, 158, 159	Elaprase	174
Dicyclomine Hcl	276	Elelyso	175
Dicyclomine Hydrochloride	276	Elfabrio	176
Differin	13	Eligard	177
Dihydroergotamine Mesylate	154, 276	Elrex fio	178
Dilaudid	853	Elyxyb	179
Dimethyl Fumarate	160	Emend	854
Dimethyl Fumarate Aet	160	Emend Tripack	854
Dimethyl Fumarate Starterpack	160	Emflaza	180
Diphenhydramine Hcl	276	Emgality	181
Dipyridamole	276	Empaveli	182
Disopyramide Phosphate	276	Empliciti	183
Dobutamine Hcl	853	Emsam	184
Dobutamine Hcl/d5w	853	Enbrel	185
Dobutamine Hydrochloride/dextrose 5%	853	Enbrel Mini	185
Dojolvi	161	Enbrel Sureclick	185
Dopamine Hydrochloride	853	Endari	186
Dopamine Hydrochloride/dextrose	853	Engerix-b	854
Dopamine/d5w	853	Enhertu	187
Doptelet	162	Enjaymo	188
Doxepin Hcl	285	Enspryng	189
Doxepin Hydrochloride	285, 701	Enstilar	98
Doxorubicin Hcl	854	Entadfi	190
Doxorubicin Hydrochloride	854	Entyvio	191
Doxycycline	493	Envarsus Xr	854
Drizalma	163	Eohilia	192
Drizalma Sprinkle	163	Epclusa	193
Dronabinol	164	Epidiolex	194
Droxidopa	458	Epiduo	13
Duexis	165	Epiduo Forte	13
Duobrii	166	Epkinly	195

Epo	196	Fentanyl Citrate Oral Transmucosal	495
Epogen.....	197	Fentanyl Patch.....	224
Epogen Aet.....	197	Fentora	495
Epoprostenol Sodium	854	Ferriprox	225
Eprontia	199	Ferriprox Twice-a-day	225
Epsolay	200	Fetzima.....	226
Eraxis.....	201	Fetzima Titration Pack.....	226
Eraxis Aet.....	201	Fexmid	295
Erbix.....	202	Fiasp Pumpcart.....	854
Ergoloid Mesylates.....	276	Filgrastim	227
Ergotamine	203	Filspari	228
Ergotamine Tartrate/caffeine.....	203	Filsuvez.....	229
Eribulin Mesylate	268	Fingolimod Hydrochloride.....	255
Erivedge	204	Fintepla	230
Erleada.....	205	Fioricet	91
Erlotinib.....	206	Fioricet/codeine.....	91
Erlotinib Hydrochloride	206	Firazyr	304
Esbriet.....	207	Firdapse.....	231
Esgic	91	Firmagon.....	232
Estazolam	300	Flebogamma Dif	338
Eszopiclone	280	Flector	233
Evenity	208	Flector Aet	233
Evenity Aet.....	208	Fleqsuvy.....	234
Everolimus	209, 854	Flolan	854
Evkeeza	211	Flucytosine.....	235
Evrysdi	213	Fluorouracil.....	103, 236, 854
Exjade.....	151	Fluticasone Furoate And Vilanterol Aet.....	237
Exkivity	214	Fluticasone Furoate/vilanterol Ellipta.....	237
Exondys 51	215	Fluticasone Propionate Diskus.....	238
Extavia.....	216	Fluticasone Propionate Hfa.....	238
Extavia Aet.....	216	Fluticasone Propionate Hfa Aet.....	238
Eylea.....	217	Form Alt Pa Metformin	239
Eylea Hd.....	218	Form Alt Pa Topical.....	240
F			
Fabhalta	219	Form Alt Pa Topical Steroids	241
Fabrazyme	220	Form Alt Pa Valsartan Sol	242
Fanapt.....	221	Form Alt Tetracycline.....	243
Fanapt Titration Pack	221	Formoterol Fumarate	519
Fareston	704	Forteo	244
Fasenra	222	Foscarnet Sodium.....	246
Fasenra Pen	222	Foscavir.....	246
Fensolvi	223	Fotivda	247
Fentanyl.....	224	Fruzaqla.....	248
Fentanyl Citrate.....	495, 854	Fulphila	447
		Fyarro.....	249

Fycompa.....	250
Fynetra.....	447
G	
Gablofen.....	854
Galafold.....	251
Gamastan.....	854
Gammagard Liquid.....	338
Gammagard S/d Iga Less Than 1mcg/ml.....	338
Gammaked.....	338
Gammaplex.....	338
Gamunex-c.....	338
Ganciclovir.....	854
Gattex.....	252
Gavreto.....	253
Gazyva.....	254
Gefitinib.....	333
Gengraf.....	854
Genotropin.....	265
Genotropin Miniquick.....	265
Gilenya.....	255
Gilotrif.....	256
Gimoti.....	257
Givlaari.....	258
Glassia.....	28
Glatiramer.....	259
Glatiramer Acetate.....	259
Glatopa.....	259
Gleevec.....	311
Gloperba.....	260
Glumetza.....	425
Glyburide.....	293
Glyburide Micronized.....	293
Glyburide/metformin Hydrochloride.....	293
Glydo.....	702
Glynase.....	293
Gonadotropin.....	261
Goprelto.....	262
Goprelto-numbrino.....	262
Granisetron Hydrochloride.....	854
Granix.....	263
Grastek.....	264
Growth Hormone.....	265
Guanfacine Hydrochloride.....	276
Guanfacine Hydrochloride Er.....	276

H

Hadlima.....	10
Hadlima Pushtouch.....	10
Haegarda.....	267
Halaven.....	268
Halcion.....	300
Halog.....	269
Halog Solution Aet.....	269
Harvoni.....	270
Hepatamine.....	854
Heplisav-b.....	854
Herceptin.....	271
Herceptin Hylecta.....	273
Herzuma.....	271
Hetlioz.....	274
Hetlioz Lq.....	275
High Risk Medication - 65.....	276
Hizentra.....	278
Hrm - Anticonvulsants - 65.....	279
Hrm - Hypnotics - 65.....	280
Hrm - Scopolamine - 65.....	282
Hrm-antiparkinson - 65.....	283
Hrm-cyproheptadine - 65.....	284
Hrm-doxepin - 65.....	285
Hrm-hydroxyzine - 65.....	286
Hrm-hydroxyzine Inj - 65.....	288
Hrm-promethazine - 65.....	289
Hrms - Antidepressants.....	290
Hrms - Carbinoxamine.....	291
Hrms - Clemastine- 65.....	292
Hrms - Diabetes Agents.....	293
Hrms - Tcas.....	294
Hrm-skeletal Muscle Relaxants - 65.....	295
Hulio.....	10
Humatrope.....	462
Humira.....	297
Humira Pen.....	297
Humira Pen-cd/uc/hs Starter.....	297
Humira Pen-pediatric Uc Starter Pack.....	297
Humira Pen-ps/uv Starter.....	297
Humulin R U-500 (concentrated).....	854
Hydrocodone Bitartrate Er.....	331
Hydromorphone Hcl.....	854
Hydromorphone Hcl Er.....	331

Hydromorphone Hydrochloride	854	Imipramine Pamoate	290
Hydromorphone Hydrochloride Er	331	Imjudo	316
Hydroxym	241	Imlygic	317
Hydroxyzine Hcl	286, 288	Imovax Rabies (h.d.c.v.)	854
Hydroxyzine Hydrochloride.....	286, 288	Impavido	318
Hydroxyzine Pamoate	286	Imuran.....	854
Hyftor	298	Imvexxy	319
Hyoscyamine Sulfate.....	276	Imvexxy Maintenance Pack	319
Hyoscyamine Sulfate Odt	276	Imvexxy Starter Pack	319
Hyperinflation Neuro-psych-pain	299	Inbrija.....	320
Hyperlyte-cr	854	Increlex	321
Hypnotic-benzodiazepines - 65	300	Indocin	276
Hyqvia	301	Indomethacin.....	276
Hyrimoz.....	10	Indomethacin Er.....	276
Hyrimoz Crohn's Disease And Ulcerative Colitis Starter Pack	10	Inflectra	322
Hyrimoz Pediatric Crohns Disease Starter Pack .	10	Infliximab.....	569
Hyrimoz Pediatric Crohn'sdisease Starter Pack ..	10	Infumorph 200	854
Hyrimoz Plaque Psoriasis/uveitis Starter Pack ...	10	Infumorph 500	854
Hysingla Er.....	331	Ingrezza.....	324
I		Inlyta	325
Ibrance.....	302	Inpefa	326
Ibsrela.....	303	Inqovi	327
Ibsrela Aet	303	Inrebic	328
Ibuprofen/famotidine.....	165	Intralipid.....	854
Icatibant.....	304	Intrarosa	329
Icatibant Acetate.....	304	Intuniv	276
Iclusig.....	305	Ipratropium Bromide	854
Idacio.....	306	Ipratropium Bromide/albuterol Sulfate.....	854
Idacio (2 Pen)	306	Iqirvo.....	330
Idacio (2 Syringe).....	306	Ir Before Er	331
Idacio Starter Package For Crohns Disease	306	Iressa	333
Idacio Starter Package For Plaque Psoriasis	306	Isolyte-s.....	854
Idhifa	307	Isolyte-s Ph 7.4.....	854
Igalmi	308	Isotretinoin	334
Ilaris.....	309	Isturisa.....	335
Ilumya.....	310	Itraconazole.....	336
Imatinib	311	Ivermectin	337
Imatinib Mesylate.....	311	Ivermectin Tab	337
Imbruvica	312	Ivig.....	338
Imdelltra	314	Iwilfin.....	340
Imfinzi	315	Ixempra	341
Imipramine Hcl	290	Ixempra Kit	341
Imipramine Hydrochloride.....	290	Izervay.....	342

J			
Jadenu.....	151	Krystexxa	372
Jadenu Sprinkle	151	Kuvan.....	609
Jakafi	343	Kyprolis.....	373
Jatenzo.....	344	L	
Javygtor	609	Lactulose	371
Jaypirca.....	345	Lagevrio	374
Jemperli	346	Lagevrio Aet	374
Jevtana.....	347	Lampit.....	375
Joenja.....	348	Lamzede.....	376
Jublia	349	Lanreotide Acetate	636
Jublia Aet.....	349	Lapatinib	377
Juxtapid	350	Lapatinib Ditosylate.....	377
Jynarque	352	Lazcluze	378
Jynneos.....	854	Ledipasvir/sofosbuvir	379
K		Ledipasvir-sofosbuvir Aet	379
Kabiven	854	Lemtrada	380
Kalbitor.....	353	Lemtrada Aet	380
Kalydeco.....	354	Lenalidomide	576
Kanjinti.....	271	Lenvima	381
Kanuma	355	Lenvima 10 Mg Daily Dose.....	381
Kerydin Aet.....	356	Lenvima 12mg Daily Dose	381
Kesimpta.....	357	Lenvima 14 Mg Daily Dose.....	381
Ketoconazole.....	358	Lenvima 18 Mg Daily Dose.....	381
Ketorolac Tromethamine.....	276, 641	Lenvima 20 Mg Daily Dose.....	381
Keveyis.....	359	Lenvima 24 Mg Daily Dose.....	381
Kevzara.....	360	Lenvima 4 Mg Daily Dose.....	381
Keytruda	361	Lenvima 8 Mg Daily Dose.....	381
Khapzory	854	Leqvio	382
Kimtrak	362	Letairis	33
Kineret.....	363	Leukine	383
Kisqali	364	Leuprolide.....	384
Kisqali Femara 200 Dose	364	Leuprolide Acetate.....	384, 410
Kisqali Femara 400 Dose	364	Levalbuterol	854
Kisqali Femara 600 Dose	364	Levalbuterol Hcl	854
Kitabis Pak	697	Levalbuterol Hydrochloride.....	854
Klisyri.....	365	Levsin.....	276
Konvomep.....	366	Levsin/sl.....	276
Korlym	367	L-glutamine.....	186
Koselugo	368	Libervant.....	385
Krazati	369	Librax	386
Krintafel	370	Libtayo	387
Kristalose.....	371	Licart.....	388
		Licart Aet	388
		Lidocaine.....	389, 702
			865

Lidocaine Hcl	702	Lupron-prostate Ca	410
Lidocaine Hydrochloride.....	702	Lybalvi	411
Lidocaine Patches.....	389	Lynparza	412
Lidocan.....	389	Lyrica	534
Lidoderm	389	Lyrica Cr	413
Lidorex	702	Lytgobi.....	414
Lidotral	240	Lyvispah.....	415
Lidotral + Hydrocortisone.....	240	M	
Lidotral 1	389	Margenza.....	416
Lidotral Hc	390	Marinol.....	164
Lidotral/hydrocortisone W/peptides & Arnica..	390	Mavenclad.....	417
Linezolid.....	391	Mavenclad Aet.....	417
Liqrev	392	Mavyret.....	418
Liraglutide	754	Mayzent.....	419
Litfulo.....	393	Mayzent Aet.....	419
Livmarli.....	394	Mayzent Starter Pack	419
Livtencity	395	Medrol.....	854
Lodoco.....	396	Mekinist	420
Lofena.....	299	Mektovi	421
Lofexidine Hydrochloride.....	401	Melphalan	854
Lonsurf	397	Memantine	422
Loqtorzi	398	Memantine Hcl Titration Pak.....	422
Lorbrena	399	Memantine Hydrochloride	422
Loreev Xr	400	Memantine Hydrochloride Er	422
Lorzone.....	295	Meperidine Hcl	276
Lotronex	27	Meprobamate	276
Lubiprostone	34	Mepron.....	423
Lucemyra.....	401	Mepron Aet.....	423
Lucentis	402	Mepsevii.....	424
Lumakras.....	403	Metaxalone.....	295
Lumizyme.....	404	Metformin Er	425
Lumryz	405	Metformin Hydrochloride.....	239
Lunesta	280	Metformin Hydrochloride Er	425
Lunsumio.....	406	Methadone Hcl.....	331
Lupkynis.....	407	Methadone Hydrochloride	331
Lupron Depot (1-month)	409, 410	Methadose	331
Lupron Depot (3-month)	409, 410	Methadose Sugar-free	331
Lupron Depot (4-month)	410	Methitest	426
Lupron Depot (6-month)	410	Methocarbamol	295
Lupron Depot-ped (1-month)	408	Methscopolamine Bromide.....	276
Lupron Depot-ped (3-month)	408	Methylprednisolone	854
Lupron Depot-ped (6-month)	408	Methylprednisolone Acetate	854
Lupron Ped	408	Methylprednisolone Sodium Succinate	854
Lupron-endometriosis	409	Methylprednisolone Sodiamsuccinate	854
			866

Methyltestosterone	426	Naproxen/esomeprazole Magnesium.....	444
Metyrosine.....	152	Naproxen-esomeprazole	444
Miacalcin.....	427	Natesto	686
Miacalcin Aet.....	427	Nayzilam.....	445
Miconazole Nitrate/zinc Oxide/white Petrolatum	428	Nebupent.....	855
Mico-zn-petr Oint.....	428	Neoral.....	855
Mifepristone	367	Nerlynx	446
Migergot.....	203	Neulasta.....	447
Miglustat	429	Neulasta Onpro Kit	447
Migranal	154	Neupogen	448
Millipred.....	854	Nexavar	449
Milrinone Lactate	854	Nexium I.v.	451
Milrinone Lactate In Dextrose	854	Nexium IV	451
Mitigo.....	854	Nexviazyme	452
Modafinil.....	430	Ngenla.....	453
Monjuvi.....	431	Ngenla Aet	453
Morphine Sulfate.....	854	Nifedipine	276
Morphine Sulfate Er.....	331	Ninlaro	454
Morphine Sulfate/sodium Chloride.....	854	Nitisinone.....	455
Motegrity.....	432	Nityr	456
Motegrity Aet.....	432	Nivestym.....	227
Mounjaro	433	Nocdurna.....	457
Mozobil	434	Nocdurna Aet.....	457
Ms Contin.....	331	Norditropin Flexpro	462
Mulpleta	435	Norgesic	295
Mvasi.....	436	Norgesic Forte.....	295
Myalept.....	437	Norpace	276
Mycapssa.....	438	Norpramin.....	290
Mycophenolate Mofetil.....	854, 855	Northera	458
Mycophenolic Acid Dr.....	855	Nourianz.....	459
Mycozyl Hc.....	240	Nourianz Aet.....	459
Myfembree	439	Novarel.....	261
Myfortic.....	855	Noxafil	460, 461, 531
Myhibbin.....	855	Noxafil Powder	460
Mylotarg.....	440	Noxafil Susp.....	461
Myobloc	441	Np Growth Hormone	462
Mytesi.....	442	Nplate.....	464
Mytesi Aet.....	442	Nubeqa	465
N		Nucala	466
Naglazyme.....	443	Nuedexta	468
Namenda.....	422	Nulev.....	276
Namenda Titration Pak.....	422	Nulibry	469
Namenda Xr	422	Nulojix	855
		Numbrino	262

Nuplazid	470
Nurtec	471
Nutrilipid	855
Nutropin Aq Nuspin 10	462
Nutropin Aq Nuspin 20	462
Nutropin Aq Nuspin 5	462
Nuvigil	43
Nyvepria	447

O

Ocaliva	472
Ocrevus.....	473
Octagam	338
Octreotide	474
Octreotide Acetate.....	474
Odactra	475
Odomzo	476
Ofev	477
Ogivri	271
Ogsiveo	478
Ojemda	479
Ojjaara	480
Olpruva.....	521
Olumiant.....	481
Omegaven.....	855
Omnitrope.....	462
Omvoh.....	482
Oncaspar	483
Ondansetron Hcl.....	855
Ondansetron Hydrochloride	855
Ondansetron Odt	855
Onfi	121
Ongentys	484
Ongentys Aet.....	484
Onivyde	485
Ontruzant.....	271
Onureg	486
Opdivo.....	487
Opdualag	488
Opfolda.....	489
Opsumit	490
Opsynvi	491
Opzelura	492
Oracea.....	493
Oracea Aet.....	493

Oralair	494
Oral-intranasal Fentanyl.....	495
Orapred Odt	855
Orencia.....	496
Orencia Clickject	496
Orenitram	497
Orenitram Titration Kit Month 1	497
Orenitram Titration Kit Month 2	497
Orenitram Titration Kit Month 3	497
Orfadin	455
Orgovyx	498
Oriahnn	499
Orilissa	500
Orkambi	501
Orladeyo.....	502
Ormalvi	359
Orphenadrine Citrate.....	295
Orphenadrine Citrate Er.....	295
Orphenadrine/aspirin/caffeine.....	295
Orphengesic Forte.....	295
Orserdu.....	503
Oscimin	276
Osphena.....	504
Otezla	505
Oxandrolone.....	506
Oxazepam	507
Oxazepam - 65	507
Oxbryta	508
Oxervate	509
Oxlumo	510
Oxycodone And Acetaminophen.....	539
Oxycodone Hcl Er.....	511
Oxycodone Hydrochloride Er.....	511
Oxycodone Hydrochloride/acetaminophen	539
Oxycodone/acetaminophen.....	539
Oxycontin.....	511
Oxycontin Aet.....	511
Oxymorphone Hydrochloride Er	331
Oxymorphone Hydrochlorideer	331
Ozempic	512

P

Padcev	513
Palforzia	514
Palforzia Initial Dose Escalation.....	514

Palforzia Level 1	514	Plegridy Starter Pack.....	525
Palforzia Level 10	514	Plenamaine.....	855
Palforzia Level 11 (maintenance)	514	Plerixafor.....	434
Palforzia Level 11 (titration).....	514	Pliaglis.....	702
Palforzia Level 2	514	Polivy	526
Palforzia Level 3	514	Pomalyst.....	527
Palforzia Level 4	514	Pombiliti.....	528
Palforzia Level 5	514	Ponvory	529
Palforzia Level 6	514	Ponvory 14-day Starter Pack	529
Palforzia Level 7	514	Ponvory Aet	529
Palforzia Level 8	514	Portrazza	530
Palforzia Level 9	514	Posaconazole.....	531
Palynziq.....	515	Posaconazole Dr.....	531
Palynziq Aet.....	515	Poteligeo	532
Panretin.....	516	Praluent	533
Panzyga	338	Prednisolone.....	855
Paroxetine.....	80	Prednisolone Sodium Phosphate.....	855
Part B Versus Part D	853	Prednisolone Sodium Phosphate Odt.....	855
Pazopanib Hydrochloride.....	768	Prednisone.....	855
Pediapred.....	855	Prednisone Intensol.....	855
Pegasys	517	Pregabalin	534
Pemazyre	518	Pregabalin Er.....	413
Pennsaid	158	Pregnyl W/diluent Benzyl Alcohol/nacl	261
Pentamidine Isethionate	855	Prehevbrio.....	855
Pentazocine/naloxone Hcl.....	276	Premasol.....	855
Perforomist.....	519	Pretomanid	535
Perforomist Aet.....	519	Pretomanid Aet	535
Perikabiven.....	855	Prevymis	536
Perjeta.....	520	Prialt.....	855
Perphenazine/amitriptyline.....	276	Privigen.....	338
Pheburane	521	Proair Digihaler.....	537
Phenergan	289	Procrit.....	196
Phenobarbital.....	279	Procysbi.....	538
Phenobarbital Sodium	279	Prograf.....	855
Phenylbutyrate.....	521	Prolastin-c	28
Phesgo	522	Prolate	539
Piasky	523	Prolate Aet	539
Piqray	524	Prolensa Aet.....	540
Piqray 200mg Daily Dose	524	Promacta	541
Piqray 250mg Daily Dose	524	Promethazine Hcl.....	289
Piqray 300mg Daily Dose	524	Promethazine Hydrochloride	289
Pirfenidone	207	Promethazine Hydrochloride Plain.....	289
Plegridy	525	Promethazine Vc.....	276
Plegridy Aet.....	525	Promethegan	289

Prosol.....	855
Protriptyline Hcl.....	294
Provigil.....	430
Prudoxin.....	701
Pulmicort.....	855
Pulmozyme.....	543
Pyrimethamine.....	146
Pyrukynd.....	544
Pyrukynd Taper Pack.....	544

Q

Qbrexza.....	545
Qdolo.....	705
Qelbree.....	546
Qinlock.....	547
Qualaquin.....	550
Quetiapine Fumarate Er.....	548
Quetiapine Xr.....	548
Quinine Sulfate.....	550
Qulipta.....	551
Qutenza.....	552
Quviviq.....	553
Quzyttir.....	554

R

Rabavert.....	855
Radicava.....	555
Radicava Ors.....	555
Radicava Ors Starter Kit.....	555
Ragwitek.....	556
Rapamune.....	855
Ravicti.....	557
Ravicti Aet.....	557
Rayos.....	855
Rebif.....	558
Rebif Open.....	558
Rebif Rebidose.....	558
Rebif Rebidose Titration Pack.....	558
Rebif Titration Pack.....	558
Reblozyl.....	559
Rebyota.....	560
Recarbrio.....	561
Recombivax Hb.....	855
Recorlev.....	562
Regranex.....	563

Releuko.....	564
Relistor.....	565, 566
Relistor Inj.....	565
Relistor Tab.....	566
Reltone.....	567
Relyvrio.....	568
Remicade.....	569
Remodulin.....	709
Renflexis.....	571
Repatha.....	573
Repatha Pushtronex System.....	573
Repatha Sureclick.....	573
Restoril.....	300, 681
Retacrit.....	196
Retevmo.....	574
Retin-a.....	703
Retin-a Micro.....	703
Retin-a Micro Pump.....	703
Revatio.....	619, 620
Revcovi.....	575
Revlimid.....	576
Reyvow.....	577
Rezdifra.....	578
Rezlidhia.....	579
Rezurock.....	580
Rezzayo.....	581
Riabni.....	582
Rinvoq.....	584
Rinvoq Lq.....	586
Rituxan.....	588
Rituxan Hycela.....	590
Rivfloza.....	591
Robaxin.....	295
Rolvedon.....	592
Rozlytrek.....	593
Rubraca.....	594
Ruconest.....	595
Rufinamide.....	60
Ruxience.....	596
Rybelsus.....	598
Rybrevant.....	599
Ryclora.....	276
Rydapt.....	600
Rylaze.....	601

Ryplazim	602
Rystiggo	603
Rytelo	604
Ryvent	291

S

Sabril	756
Saizenprep Reconstitutionkit.....	462
Sajazir.....	304
Samsca.....	605
Sandimmune.....	855
Sandostatin	474
Sandostatin Lar.....	606
Sandostatin Lar Depot.....	606
Saphnelo	608
Sapropterin	609
Sapropterin Dihydrochloride.....	609
Sarclisa	610
Savella	611
Savella Titration Pack	611
Scemblix.....	612
Scopolamine	282
Seglentis	613
Seroquel Xr	548
Serostim.....	614
Seysara	615
Signifor.....	616
Signifor Lar	617
Siklos.....	618
Sildenafil	619, 620
Sildenafil Citrate	619
Sildenafil Inj.....	620
Siliq	621
Simlandi 1-pen Kit	10
Simlandi 2-pen Kit	10
Simponi	622
Simponi Aria	624
Simulect.....	855
Sirolimus	855
Sirturo.....	626
Skyclarys	627
Skyrizi	628
Skyrizi Pen	628
Skytrofa.....	629
Skytrofa Aet	629

Smoflipid.....	855
Sodium Oxybate.....	813
Sodium Phenylbutyrate.....	521
Sofosbuvir And Velpatasvir Aet.....	630
Sofosbuvir/velpatasvir	630
Sogroya	631
Sogroya Aet	631
Sohonos.....	633
Soliris	634
Solu-medrol.....	855
Soma	295
Somatuline Depot.....	636
Somavert	637
Sorafenib Tosylate	449
Sorilux.....	98
Sotyktu	638
Sovaldi	639
Sovaldi Aet.....	639
Spevigo	640
Sporanox	336
Sprix.....	641
Sprycel	642
Stelara	644
Stimufend.....	645
Stivarga	646
Strensiq	647
Stromectol.....	337
Sublocade.....	648
Subsys	495
Sunitinib Malate.....	651
Sunosi.....	649
Susvimo.....	650
Sutent	651
Syfovre.....	653
Sylvant	654
Symdeko	655
Symlin.....	656
Symlinpen 120	656
Symlinpen 60	656
Sympazan.....	657
Syndros	164
Synera	658
Synera Aet.....	658
Syprine	710

T	
Tabrecta.....	659
Taclonex.....	98
Tacrolimus.....	855
Tadalafil.....	660
Tadalafil (pah).....	660
Tadliq.....	660
Tafinlar.....	661
Tagrisso.....	663
Takhzyro.....	664
Taltz.....	665
Talvey.....	667
Talzenna.....	668
Tanlor.....	295
Tarceva.....	206
Targretin.....	72, 669
Targretin Topical.....	669
Tarpeyo.....	670
Tascenso.....	671
Tascenso Odt.....	671
Tasigna.....	672
Tasimelteon.....	274
Tavaborole.....	356
Tavalisse.....	673
Tavneos.....	674
Tazarotene.....	675
Tazorac.....	675
Tazverik.....	676
Tecentriq.....	677
Tecfidera.....	678
Tecfidera Starter Pack.....	678
Tecvayli.....	679
Tegsedi.....	680
Temazepam.....	300, 681
Temazepam 30mg - 65.....	681
Tencon.....	91
Tepezza.....	682
Tepmetko.....	683
Teriflunomide.....	684
Teriparatide.....	244
Testim.....	686
Testopel.....	685
Testosterone Aet.....	686
Testosterone Cypionate Inj.....	687
Testosterone Enanthate.....	688
Testosterone Enanthate Inj.....	688
Tetrabenazine.....	689
Tetracycline Hydrochlorid.....	243
Tetracycline Hydrochloride.....	243
Tevimbra.....	690
Tezspire.....	691
Thalomid.....	692
Thioridazine Hcl.....	276
Thymoglobulin.....	855
Tibsovo.....	693
Tigan.....	276
Tivdak.....	694
Tlando.....	695
Tobi.....	697
Tobi Inhaler.....	696
Tobi Podhaler.....	696
Tobramycin.....	697
Tofidence.....	698
Tolak.....	699
Tolsura.....	700
Tolvaptan.....	605
Topical Doxepin.....	701
Topical Lidocaine.....	702
Topical Tretinoin.....	703
Toremifene.....	704
Toremifene Citrate.....	704
Torpenz.....	209
Tpn Electrolytes.....	855
Tracleer.....	76
Tramadol Hydrochloride.....	299, 705
Tramadol Oral Solution.....	705
Transderm-scop.....	282
Travasol.....	855
Trazimera.....	706
Trelstar.....	707
Trelstar Mixject.....	707
Tremfya.....	708
Treprostinil.....	709
Treprostinil Inj.....	709
Tretinoin.....	703
Tretinoin Microsphere.....	703
Tretinoin Microsphere Pump.....	703
Triazolam.....	300

Tridacaine.....	389	Vabysmo.....	734
Tridacaine II.....	389	Valchlor.....	735
Trientine.....	710	Valium.....	156
Trientine Hydrochloride.....	710	Valsartan.....	242
Trihexyphenidyl Hcl.....	283	Valtoco.....	736
Trihexyphenidyl Hydrochloride.....	283	Valtoco 10 Mg Dose.....	736
Trikafta.....	711	Valtoco 15 Mg Dose.....	736
Trimethobenzamide Hydrochloride.....	276	Valtoco 20 Mg Dose.....	736
Trimipramine Maleate.....	294	Valtoco 5 Mg Dose.....	736
Triptodur.....	712	Vanflyta.....	737
Trodelvy.....	713	Varenicline Starting Month Box.....	109
Trophamine.....	856	Varenicline Tartrate.....	109
Trudhesa.....	154	Varubi.....	856
Trulicity.....	714	Vecamyl.....	738
Truqap.....	715	Vectibix.....	739
Truseltyq.....	716	Vectical.....	98
Truxima.....	717	Vegzelma.....	740
Tukysa.....	719	Veklury.....	741
Turalio.....	720	Velcade.....	742
Twynéo.....	703	Veletri.....	856
Tyenne.....	721	Velsipity.....	743
Tykerb.....	377	Veltin.....	703
Tymlos.....	722	Venclexta.....	744
Tysabri.....	724	Venclexta Starting Pack.....	744
Tyvaso.....	725	Ventavis.....	745
Tyvaso Dpi.....	726	Veopoz.....	746
Tyvaso Dpi Maintenance Kit.....	726	Veozah.....	747
Tyvaso Dpi Titration Kit.....	726	Verkazia.....	748
Tyvaso Refill Kit.....	725	Versacloz.....	749
Tyvaso Starter Kit.....	725	Verzenio.....	750
Tzield.....	727	Vevye.....	751
U			
Ubrelvy.....	728	Vfend.....	766
Udenyca.....	447	Vfend IV.....	766
Udenyca Onbody.....	447	Vibativ.....	752
Ultomiris.....	729	Vibativ Aet.....	752
Uplizna.....	730	Viberzi.....	753
Uptravi.....	731	Victoza.....	754
Uptravi Titration Pack.....	731	Victoza Aet.....	754
Ursodiol.....	567	Viekira Aet.....	755
Uzedy.....	732	Viekira Pak.....	755
V			
Vabomere.....	733	Vigabatrin.....	756
		Vigadrone.....	756
		Vigafyde.....	757
		Vigpoder.....	756

Vijoice.....	758
Viltepsol.....	759
Vimizim.....	760
Vimovo.....	444
Vinblastine Sulfate.....	856
Vincasar Pfs.....	856
Vincristine Sulfate.....	856
Vistaril.....	286
Vitrakvi.....	761
Vivjoa.....	762
Vizimpro.....	763
Vogelxo.....	686
Vogelxo Pump.....	686
Vonjo.....	764
Voranigo.....	765
Voriconazole.....	766
Vosevi.....	767
Votrient.....	768
Vowst.....	769
Voxzogo.....	770
Voydeya.....	771
Vpriv.....	772
Vtama.....	773
Vuity.....	774
Vumerity.....	775
Vusion.....	428
Vyepti.....	776
Vyjuvek.....	777
Vyndamax.....	778
Vyndaqel.....	779
Vyondys 53.....	780
Vyvgart.....	781
Vyvgart Hytrulo.....	782
Vyxeos.....	783

W

Wainua.....	784
Wakix.....	785
Welireg.....	786
Winlevi.....	787
Winrevair.....	788

X

Xalkori.....	789
Xdemvy.....	790

Xeljanz.....	791
Xeljanz Xr.....	791
Xembify.....	793
Xenazine.....	689
Xenleta.....	794
Xenpozyme.....	795
Xeomin.....	796
Xermelo.....	797
Xgeva.....	798
Xhance.....	799
Xhance Mapd.....	799
Xiaflex.....	800
Xifaxan.....	801, 802
Xifaxan200.....	802
Xipere.....	803
Xolair.....	804
Xolremdi.....	806
Xospata.....	807
Xphozah.....	808
Xpovio.....	809
Xpovio 60 Mg Twice Weekly.....	809
Xpovio 80 Mg Twice Weekly.....	809
Xtampza Er.....	331
Xtandi.....	810
Xuriden.....	811
Xyosted.....	812
Xyosted Aet.....	812
Xyrem.....	813
Xywav.....	814

Y

Yargesa.....	429
Ycanth.....	816
Yervoy.....	817
Yondelis.....	818
Yonsa.....	819
Yuflyma 1-pen Kit.....	10
Yuflyma 2-syringe Kit.....	10
Yuflyma Cd/uc/hs Starter.....	10
Yupelri.....	820
Yupelri Aet.....	820
Yusimry.....	10

Z

Zaleplon.....	280
---------------	-----

Zaltrap	821	Zolpidem Cap.....	838
Zarxio	822	Zolpidem Tartrate	280, 838
Zavesca.....	429	Zolpidem Tartrate Er.....	280
Zavzpret.....	823	Zolpimist.....	280
Zebutal.....	91	Zomacton	462
Zegerid	824, 825	Zonalon	701
Zegerid Capsule Aet.....	824	Zonisade.....	839
Zegerid Suspension Aet	825	Zorbtive.....	840
Zejula.....	826	Zortress	856
Zelboraf.....	827	Zoryve	841, 842, 843
Zemaira.....	28	Zoryve 0.15 Percent Cream	842
Zemdri	828	Zoryve Foam.....	843
Zenatane	334	Ztalmy	844
Zepatier.....	829	Ztlido.....	845
Zepatier Aet.....	829	Ztlido Aet.....	845
Zeposia	830	Zulresso.....	856
Zeposia 7-day Starter Pack.....	830	Zurzuvae	846
Zeposia Starter Kit	830	Zydelig	847
Zepzelca	831	Zykadia	848
Ziana.....	703	Zymfentra 2-pen.....	849
Ziextenzo.....	447	Zymfentra 2-syringe.....	849
Zilbrysq	832	Zymfentra Aet.....	849
Zilxi	833	Zynlonta	850
Zinplava.....	834	Zynyz	851
Zipsor	299	Zyprexa Relprevv.....	852
Zirabev	835	Zytiga	4
Zokinvy	836	Zyvox	391
Zolinza.....	837		